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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Deaf Blind with Multiple Disabilities

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

D. Amendment Number:TX.0281.R04.03

E. Proposed Effective Date: *(mm/dd/yy)*
02/28/16
Approved Effective Date: 02/28/16
Approved Effective Date of Waiver being Amended: 03/01/13

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
Appendix C-1/C-3 Residential Habilitation (Statutory Service).
The majority of activities included as part of the waiver Residential Habilitation (HAB) services are now available through the non-waiver resource state plan Community First Choice (CFC) Personal Assistance Services (PAS)/HAB service. Thus, the service definition for residential habilitation in the DBMD waiver is being amended to reflect this change. The definition of habilitation from the Texas Administrative Code that addresses the DBMD waiver is being added to the waiver application for clarification of what habilitation means in general. The list of services has been altered to bulleted format rather than listed in a paragraph format for ease of reference and consistency with the Texas Administrative Code language. And the limits section has been updated to reflect the language in the Texas Administrative Code as follows: (1) the new language in the limits section reflects that payment will not be made for the routine care and supervision that a family member "is legally obligated to provide." The previous language used in the application was "would be expected to be provided" rather than "is legally obligated to provide"; and (2) the new language in the limits section states that the service may not be provided at the same time that "licensed" assisted living "or licensed home health assisted living" is provided. The quoted language has been added for consistency with the Texas Administrative Code language.

Appendix C-1/C-3 and Appendix J
Prescribed Drugs (Extended State Plan Service) The waiver is being changed to clarify eligibility for prescription drugs through the DBMD waiver program. As a result of the transition from the fee-for-service delivery method to the managed

care delivery method, effective September 1, 2014, individuals in the waiver who are enrolled in managed care for their acute care services receive unlimited prescription medications through their managed care and therefore do not qualify for prescriptions through the waiver. Dual eligible individuals are excluded from enrollment into managed care and, thus, are still eligible for prescription medications through the waiver if they exhaust non-DBMD waiver resources first (such as the Medicare Prescription Drug Plan and the Texas Medicaid State Plan resources). The acute versus waiver dollars for prescriptions will be revised to better reflect the source of funding for prescription costs.

Appendix B-6i
The waiver is being amended to remove the requirements for the direct services agency to submit a separate level of care instrument to prevent a gap in services. In addition, the waiver is being amended to add that if reinstatement is granted, reinstatement will only be effective for up to 180 calendar days before the date DADS receives the current Form 8578, or the first day of the new individual plan of care period, whichever is more recent.

Appendix B-3f
Effective November 2015, rule amendments will be made updating the process for individuals on the DBMD interest list. The primary changes to the waiver application and the rules are in relation to policies for individuals interested in being on the interest list who are military family members temporarily living out of state. Military family members will not be removed from the DBMD interest list for temporarily moving outside of the state of Texas due to the military member's assignment. If an applicant who is a military family member is offered enrollment while temporarily living outside of Texas they shall retain their position on the interest list for up to one year after their family's military service ends. The waiver application also adds clarifying language that the reserved capacity group, "Money Follows the Person," bypasses the interest list.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☐ **Appendix A – Waiver Administration and Operation**	
☑ **Appendix B – Participant Access and Eligibility**	B-3f, B6i
☑ **Appendix C – Participant Services**	C-1/C-3
☐ **Appendix D – Participant Centered Service Planning and Delivery**	
☐ **Appendix E – Participant Direction of Services**	
☐ **Appendix F – Participant Rights**	
☐ **Appendix G – Participant Safeguards**	
☐ **Appendix H**	
☐ **Appendix I – Financial Accountability**	
☑ **Appendix J – Cost-Neutrality Demonstration**	

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

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

Specify:

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

1. Request Information (1 of 3)

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

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

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: TX.0281
Waiver Number:TX.0281.R04.03
Draft ID: TX.018.04.03

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

E. Proposed Effective Date of Waiver being Amended: 03/01/13
Approved Effective Date of Waiver being Amended: 03/01/13

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

☐ **Nursing Facility**

Select applicable level of care

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

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

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:
Enrollment in the waiver is limited to individuals qualifying for an intermediate care facility level of care VIII.

1. Request Information (3 of 3)

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

- (●) **Not applicable**
- ( ) **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

  Specify the program:

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

- [x] **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The Deaf Blind with Multiple Disabilities (DBMD) waiver, first authorized March 1, 1995, provides community based services and supports to individuals with legal blindness, deafness, or a condition that leads to deafblindness, and at least one additional disability that limits functional abilities. The goals of the DBMD waiver are to assist an individual to live in his/her own home, parent's or guardian's home, or in a small group home setting. These goals are intended to enhance quality of life, functional independence, health, and well-being. Services are intended to enhance, rather than replace, existing informal or formal supports and resources. Residential habilitation, respite, intervener, supported employment, and employment assistance are available through both the consumer directed option and the traditional agency option.

Individuals enrolling in the waiver choose a DBMD provider agency from a list of all agencies contracted with the State to provide DBMD services. Once an agency is chosen, a case manager from the chosen agency facilitates the applicant's enrollment and arranges for an initial service planning team meeting to determine needed services. The single State Medicaid Agency, the Health and Human Service Commission (HHSC), exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. HHSC directly performs financial eligibility determinations for applicants; develops the reimbursement rate methodology and sets reimbursement rates; and conducts Medicaid fair hearings in accordance with 42 CFR §431 Subpart E, and as described in

Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A (relating to Uniform Fair Hearing Rules).

HHSC delegates routine functions necessary to the operation of the waiver to the operating agency, the Department of Aging and Disability Services (DADS). These functions include participant waiver enrollment; waiver enrollment managed against approved limits; waiver expenditures managed against approved levels; level of care evaluation; review participant service plans; prior authorization of waiver services; utilization management; qualified provider enrollment; execution of Medicaid provider agreements; development of rules policies, procedures and information development governing the waiver program; and quality assurance and quality improvement activities.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ( ) **Not Applicable**
- (●) **No**
- ( ) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

I. Public Input. Describe how the State secures public input into the development of the waiver:
HHSC distributed the DBMD Amendment 3 Tribal Notification to the tribal representatives on September 30, 2015, in compliance with the 60 day federal and state requirements. The Tribal Notification provided contact information to request copies of the amendment, provide comments, and/or request information from the State via email, mail, fax, or telephone. The State provides copies free of charge.

The Public Notice of Intent (PNI) was published in the Texas Register on October 9, 2015, at page 7139 (http://www.sos.state.tx.us/texreg/pdf/backview/1009/1009ia.pdf), allowing a 30-day comment period in compliance with federal and state requirements. The Texas Register is published weekly and is the journal of state agency rulemaking for Texas. In addition to activities related to rules, the Texas Register publishes various public notices including attorney general opinions, gubernatorial appointments, state agency requests for proposals and other documents, and it is used regularly by stakeholders. HHSC publishes all Medicaid waiver submissions in the Texas Register in addition to many other notices. The publication is available online and in hard copy at the Texas State Library and Archives Commission, the State Law Library, the Legislative Reference Library located in the State Capitol building, and the University of North Texas libraries. All of these sites are located in Austin, except for the University of North Texas, which is located in Denton. Printed copies of the Texas Register are also available through paid subscription; subscribers include cities, counties and public libraries throughout the state. The PNI provided contact information to request copies of the amendment, provide comments, and/or request information from the State via email, mail, fax, or telephone. The State provides copies free of charge. Additionally, on Octber 13, 2015, HHSC sent a request to the HHSC Office of Social Services to distribute notice of the amendment to 290 local eligibility offices with instructions to post the notice in public areas. State staff posted the DBMD Waiver Amendment 3 on the DBMD Waiver page on the DADS website (http://www.dads.state.tx.us/providers/dbmd/) on October 16, 2015. No public comments or requests for copies were received during the 30-day public comment period.

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

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

7. Contact Person(s)

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

Last Name:

Brownlee

First Name:

Becky

Title:

Director, Policy Development Support

Agency:

Texas Health and Human Services Commission

Address:

4900 North Lamar Blvd.

Address 2:

Mail Code H-620

City:

Austin

State:

Texas

Zip:

78751

Phone:

(512) 462-6281 **Ext:** ☐ **TTY**

Fax:

(512) 730-7472

E-mail:

Becky.Brownlee@hhsc.state.tx.us

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

Last Name:

Williamson

First Name:

Dana

Title:

Manager of Waiver and State Plan Services

Agency:

Department of Aging and Disability Services

Address:

701 West 51st Street

Address 2:

P.O. Box 149030, Mail Code: W579

City:

Austin

State:

Texas

Zip:

78714-9030

Phone:

(512) 438-3385 **Ext:** ☐ **TTY**

Fax:

(512) 438-4415

E-mail:

dana.williamson@dads.state.tx.us

8. Authorizing Signature

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

Signature:

Jacqueline Pernell

State Medicaid Director or Designee

Submission Date:

Feb 1, 2016

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

Last Name:

Gary
First Name:

Jessee
Title:

State Medicaid Director
Agency:

Texas Health and Human Services Commission
Address:

4900 North Lamar Blvd
Address 2:

Mail Code H-620
City:

Austin
State:
Texas
Zip:

78621

Phone:

(512) 462-6205 **Ext:** ☐ **TTY**

Fax:

(512) 730-7472

E-mail:

gary.jessee@hhsc.state.tx.us

Attachments

Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

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

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301 (c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

DBMD Settings Transition Plan

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

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

The State administers the Deaf Blind with Multiple Disabilities (DBMD) program that provides home and community-based services to individuals with deaf blindness or a condition that will result in deaf-blindness as an alternative to living in an intermediate care facility for individuals with intellectual disabilities. Recipients may live in their own home, their family's home or in a small (4-6 bed) assisted living facility.

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

Assessment Process:

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

Systemic review: The State first determines its current level of compliance with the settings requirements. The State assesses the extent to which its rules, regulations, standards, policies, licensing requirements, and other provider requirements ensure settings comport with the HCBS settings requirements. In addition, the State assesses and describes the

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

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

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

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

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

http://www.dads.state.tx.us/providers/HCBS/hcbs-settingsassessment.pdf

Day habilitation and assisted living (1-3 bed home or 4-6 bed home) settings will be considered in the assessment process as well as in the remediation phase if necessary. In addition, supported employment and employment assistance are included in the assessment to ensure these services are being provided in environments that are competitive and integrated employment settings. Per CMS guidance, a setting where the individual resides in their own home or family home is presumed to be compliant.
In July and August 2014 the State gave public notice for preliminary settings transition plans for CBA, CLASS, HCS, MDCP, and YES. Comments received were considered for incorporation into the assessment. Some suggestions were already underway, for example, the State was already in the process of adding supported employment and employment assistance to the waivers.

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

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

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

- Provider self-assessment surveys: In order to validate the results of the first assessment phase, DADS is releasing a provider self-assessment survey to a representative sample of providers. The survey will be based on the exploratory questions provided by CMS with input from external stakeholders. The provider self-assessment survey will be developed in conjunction with providers, provider associations and advocacy organizations to ensure a comprehensive approach. Providers who are not a part of the sample can still obtain and complete a self-assessment survey on the agency websites and provide data that will be considered as the State moves forward. Based on the results of the survey, ongoing remediation strategies and the assessment document will be updated.
- Participant surveys: In order to validate the provider self-assessment surveys, DADS is releasing a participant survey to a representative sample of individuals receiving services. The survey will be based on the questions asked in the provider self-assessment. Participants who are not a part of the sample can still obtain and complete a participant survey on the agency websites and provide data that will be considered as the State moves forward. Based on the results of the survey, ongoing remediation strategies and the DADS assessment document will be updated.
- Site specific assessments: DBMD and CLASS residential providers are small in number and state resources provide for onsite visits of DBMD providers offering assisted living residential services and CLASS providers offering support family services to validate provider self-assessment results.
- Stakeholder meetings: The State is developing a plan for holding meetings around the state to allow providers, advocates, individuals receiving services, legally authorized representatives and other interested parties the opportunity to comment on all 1915(c) waiver programs and any concerns regarding compliance with the new regulations.
- National Core Indicators (NCI) Data: The State is in the process of analyzing NCI data and will consider using it in the assessment process.

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

Third Phase of Assessment June 2015-May 2016

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

Remedial Strategy:

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

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

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

update the Settings Transition Plan and timeline accordingly.

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

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

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

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

Public Input and Notice:

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

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

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

The State intends to reach out throughout the transition to State staff, providers, advocates, and individuals receiving

services and their families. Through various venues, the State plans to educate providers about their responsibilities, help individuals understand their rights under the new HCBS requirements, and solicit input.

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

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

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

- Stakeholder education webinars: DADS conducted two webinars on September 11 and September 14, 2014, to provide all stakeholders an opportunity to learn about the new regulations prior to the October 13, 2014 open meeting held in Austin.
- Stakeholder meetings: On October 13, 2014, the State held an open stakeholder meeting in Austin providing all stakeholders the opportunity to provide input on the new regulations.
- Electronic notices: The State posted the Statewide Settings Transition Plan on agency websites and in the Texas Register in November 2014. The DADS assessment was also posted on the agency website. The preliminary transition plans for several of the waivers were posted in the Texas Register and on the agency websites.
- Feedback mechanism: Dedicated electronic mail boxes and websites for HHSC and DADS are available to provide information about the new rules and accept feedback. The websites and the option to make comments will remain active throughout the transition and the State will take any comments received into consideration, until the State completes the transition. State websites are located at the following:
http://www.hhsc.state.tx.us/medicaid/hcbs/index.shtml
http://www.dads.state.tx.us/providers/HCBS/index.cfm
- Presentations at statutorily mandated committees: The State regularly provides updates to the following groups and offers them opportunities to comment on ongoing assessment and remediation activities:
-Promoting Independence Advisory Committee: comprised of individuals receiving services, advocacy organizations, and providers across target populations.
-Employment First Task Force: comprised of advocates and providers interested in employment issues.
-Texas Council on Autism and Pervasive Developmental Disorders: comprised of parents of individuals with autism and professionals.
-IDD Redesign Advisory Committee: comprised of individuals receiving services, advocacy organizations and providers.
- Presentations at agency workgroups: The agencies also have agency-established workgroups comprised of advocates and providers whose purpose is to examine ongoing rule and policy issues. Staff will provide updates on HCBS transition activities and provide the workgroup members the opportunity to provide comments.
- Presentations at conferences: Provider associations hold annual conferences and State staff have been invited to speak at these conferences. This provides access to a large number of providers for purposes of education, coordination and input regarding changes being made to rules and policy.

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

Timeline of DBMD Settings Transition Planning

*Represents milestone activities

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

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

waivers for all settings referenced in the rule that are applicable to this waiver, for example, assisted living and settings in which supported employment and employment assistance are provided .
2) State staff identification of areas in which policy and rules appeared to be silent or in contradiction with new HCBS rules.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Public Input

1) *July 2014 – September 2014: Internal assessment document outlining compliance and non-compliance with settings requirements across all 1915(c) waivers operated by DADS posted for public input.
2) July 2014 continuing through the end of the transition period: Presentations to statutorily mandated committees and agency workgroups that have provider and advocate membership will continue throughout the assessment process. Stakeholders will have multiple opportunities to provide input.

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

4) September 2014 continuing through the end of the transition period: DADS HCBS website and electronic mailbox is

available to collect stakeholder input and allow public comment on the State's activities toward compliance with the settings requirements.

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

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

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

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

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

DBMD REMEDIATION Activities : November 2014 – June 2018

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

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

3)January 2016 – December 2016*: Amend DBMD program rules and Chapter 49 contracting rules to address all applicable settings, for example, those rules governing assisted living facilities and employment services, to ensure the services comply with the new HCBS guidelines. Stakeholder input is actively solicited during the rule making process.

4)April 2016 – December 2016: Revise the DBMD policy manual, including rights and responsibilities forms/publications, to further outline HCBS requirements for all settings referenced in the rule that are applicable to this waiver, for example, assisted living and settings in which supported employment and employment assistance are provided.

5)June 2016 – March 2017: Develop a new contract monitoring tool for all settings referenced in the rule that are applicable to this waiver, for example, assisted living and settings in which supported employment and employment assistance are provided to incorporate HCBS setting requirements. The revised monitoring tools will be used to ensure providers are compliant with the new rules and policies aimed at compliance with the HCBS regulations.

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

7)December 2016 – March 2017: Review and include appropriate revisions to the DBMD Settings Transition Plan.

8)April 2017 – May 2017: Public notice and public comment period for review of the revised DBMD Settings Transition Plan.

9)June 2017 – June 2017*: Submit DBMD amendment updating the Settings Transition Plan with appropriate changes based on public input after the required public notice.

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

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

12)June 2017 – March 2018: Develop a new contract monitoring tool for day habilitation services. The revised monitoring tools will be used to ensure providers are compliant with the new rules and policies aimed at compliance with the HCBS regulations.

13)December 2017 – March 2018: Review and include appropriate revisions to the DBMD Settings Transition Plan.

14)April 2018 – May 2018: Public notice and public comment period for review of the revised DBMD Settings Transition Plan.

15)June 2018 – June 2018*: Submit DBMD amendment updating the Settings Transition Plan with appropriate changes based on public input after the required public notice.

STAKEHOLDER COMMENTARY

The state has added the Statewide Transition Plan comments specific to the DBMD waiver to the amendment. The Texas Department of Aging and Disability Services (DADS) has updated the transition plan to include public comments specific to the DBMD waiver as listed below. Additional comments which were applicable to all waivers are not included in this response and update, since CMS has acknowledged that those comments are included in the Statewide Transition Plan. If CMS, however, is expecting the State to include the comments applicable to all waivers in this response and update, please advise.

Comment: Commenters indicated that HCBS settings exclude locations that have qualities of an institutional setting and stated the commenters felt that the DBMD program currently does not meet that standard because it allows for services to be provided to individuals in assisted living facilities with up to 6 individuals in a home.
STATE RESPONSE:
The State does not presume that the State's DBMD 4-6 bed assisted living facilities are settings that have the qualities of an institution, such that they would be subject to heightened scrutiny. However, the statewide settings transition plan already identifies a process for assessing compliance with the new HCBS rules and for any necessary rule and policy manual revisions.

Comment: Commenters recommended that the DBMD waiver include a core set of community integration principles.
STATE RESPONSE:

The statewide settings transition plan already provides opportunities for the State to assess the level of community integration through the existing statewide settings transition assessment process and to make appropriate changes as necessary in the existing remediation phase.
Comment: Commenters suggested that the DBMD waiver needs attention and work to ensure compliance with HCBS settings rules regarding the protection of each individual's privacy. The commenters stated that §42.630 of the Texas Administrative Code which specifies the residential service requirements of the DBMD waiver need to be amended to ensure that each individual's privacy is protected.
STATE RESPONSE:

The State will assess the level of community integration through the existing statewide settings transition assessment process and make appropriate changes as necessary in the existing remediation phase.
Comment: With regard to the DBMD waiver, commenters indicated that further review of residential services is required to address inclusion of a private unit option for individuals.
STATE RESPONSE:

The State will assess residential services through the existing statewide settings transition assessment process and make appropriate changes as necessary in the existing remediation phase.

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

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

   (Complete item A-2-a).

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

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

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify

the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
In 2004, the Texas Legislature consolidated ten health and human service agencies into four agencies (including DADS) to operate under the authority and oversight of the Health and Human Services Commission (HHSC). In accordance with Title 42 of the Code of Federal Regulations, Section 431.10, HHSC is designated as the single State Medicaid Agency and, therefore, has administrative authority over the waiver programs. The Texas Legislature gave HHSC plenary authority to supervise and operate the Medicaid program, including monitoring and ensuring the effective use of all federal funds received by the state's health and human services agencies.

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

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

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

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

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

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

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

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

HHSC reviews and approves all waiver renewals, amendments and evidentiary reports, and the CMS-372 reports that are developed by DADS. In addition, HHSC reviews all waiver program policies and operations

that impact the waiver application and may request that DADS modify, clarify, or provide additional information in considering approval or disapproval of proposed changes.

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

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

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

Appendix A: Waiver Administration and Operation

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

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

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

Appendix A: Waiver Administration and Operation

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

   ◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

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

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. **Performance Measures**

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

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

Where possible, include numerator/denominator.

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

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

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

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

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Directive from the Executive Commissioner of HHSC to DADS Concerning the Operation of Home and Community Based Services 1915(c) Waivers; HHSC 1915(c) Sharepoint Site

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

☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
DADS Service Authorization System

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

Data Aggregation and Analysis:

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
DBMD Database; DADS Quality Assurance and Improvement Datamart

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

Data Aggregation and Analysis:

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

Performance Measure:
A.a.7 Number and percent of case records reviewed by DADS as part of contract monitoring in accordance with the executive directive. N: Number of case records reviewed D: Number of case records required to be reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Individual cases are selected for review based on a five percent sample with a minimum of two

		individual cases reviewed.
	☑ **Other** Specify: Biennial	

Data Aggregation and Analysis:

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

Performance Measure:
A.a.8 Number and percent of paid claims for services that are prior authorized by DADS. N: Number of individuals whose services were authorized by DADS prior to service delivery D: Number of claims submitted

Data Source (Select one):
Other
If 'Other' is selected, specify:
DADS Service Authorization System

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
DBMD Database

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:
Health and Human Services Contract Administration and Tracking System; DADS Contracts Database

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

Data Aggregation and Analysis:

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

Performance Measure:
A.a.12 Number and percent of providers with actions taken by DADS based upon results of contract monitoring. N: Number of providers that have actions taken on their contract D: Number of providers monitored

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

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

Data Aggregation and Analysis:

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Health and Human Services Contract Administration Tracking System; DADS Automated Survey Processing Environment system

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

Data Aggregation and Analysis:

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
HHSC and DADS hold regular status and update meetings directed at evaluating current quality systems and identifying and prioritizing enhancements. HHSC has formal processes to ensure that the waiver renewal, waiver amendments, CMS-372 reports, Request for Evidentiary Information reports, and all state rules for waiver program operations are reviewed and approved by HHSC.

b. Methods for Remediation/Fixing Individual Problems

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

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

Informal conversations

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

Waiver Strategic Planning meetings

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

Elevated conversations

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

Action memos

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

Corrective Action Plan

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

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

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

An eligible individual must:

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

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

    Specify the percentage:

  - ◉ **Other**

    Specify:

    The cost limit is $114,736.07.

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

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

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

  - ○ **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

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

      Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

An individual whose request for eligibility for the waiver program is denied or is not acted upon with reasonable promptness is entitled to a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A. DADS sends written notification to the individual's DBMD provider who notifies the individual, or legally authorized representative, of the individual's right to a fair hearing and the process to follow to request a fair hearing.

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

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

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

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

☑ **Other safeguard(s)**

Specify:

All waiver individuals must have a service plan at a cost within the cost limit. For individuals with needs that exceed the cost limit, DADS has a process to ensure their needs are met. The process includes examining non-waiver resources including institutional services if necessary and appropriate.

During the enrollment process and at least annually the case manager will inform the individual of other options and make referrals as appropriate. If DADS proposes to terminate the individual's waiver eligibility or reduce services, DADS will give the individual or legally authorized representative the opportunity to request a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A.

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	192
Year 2	218
Year 3	218
Year 4	218
Year 5	218

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	180
Year 2	206
Year 3	206
Year 4	206
Year 5	206

Appendix B: Participant Access and Eligibility

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

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

- ○ **Not applicable. The state does not reserve capacity.**
- ◉ **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
Money Follows the Person	

Appendix B: Participant Access and Eligibility

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

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

Money Follows the Person

Purpose *(describe):*

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

Texas also contracts with relocation contractors who employ relocation specialists that assist in the outreach and identification of individuals interested in relocation and then assist them in the relocation process. Relocation contractor services are available throughout Texas. If an individual chooses to relocate from a nursing facility to the community, the relocation specialist coordinates the relocation with the resident, the resident's family (or guardian/legally authorized representative), the facility, and the individual's provider case manager. In addition, representatives from the following organizations also provide information and assistance for nursing facility residents wanting to return to a community setting:

•DADS case manager
•Local Area Agencies on Aging;
•Local Long-Term Care Ombudsmen;
•Nursing Facility Social Workers;
•Nursing Facility Family Councils;
•Local Long-Term Services and Supports Providers;
•Community Transition Teams; and
•Aging and Disability Resource Centers.

Describe how the amount of reserved capacity was determined:

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

If legislative funding is not available, DADS maintains a DBMD interest list and assigns placement on the interest list chronologically based on the date of the request for DBMD services. The individual must reside in the state of Texas with the exception of an individual who who is a military family member (the spouse or child of a military member). Military family members will not be removed from the DBMD interest list for temporarily moving outside of the state of Texas due to the military member's assignment. If an applicant who is a military family member is offered enrollment while temporarily living outside of Texas they shall retain their position on the interest list for up to one year after their family's military service ends.

DADS offers a vacancy to individuals on a “"first-come, first-served"” basis as funding is available and according to the chronological date of the registration on the DBMD interest list unless the individual is residing in a nursing facility and requesting DBMD Program services through Money Follows the Person (the reserved capacity group). As previously described, Money Follows the Person helps individuals living in a nursing facility return to the community to receive their long-term services and supports without having to be placed on an interest list.

Once an offer to apply for DBMD is made, the individual must choose a DBMD provider from a list of contracted DBMD providers and notify DADS of the choice of provider. DADS then notifies the chosen provider. The provider case manager must schedule and conduct a face-to-face contact with the individual to begin the eligibility process. The individual must meet Medicaid eligibility requirements, meet level of care eligibility, assist the DBMD provider agency with obtaining a completed level of care from the physician, and have an ongoing need for services. Once the level of care assessment is obtained from the physician, the provider case manager schedules a service planning team meeting to determine the services to be included in the service plan and the date for services to begin.

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

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

Appendix B: Participant Access and Eligibility

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

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

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ( ) **No**
   - (●) **Yes**

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

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

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

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

  Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

  Transitional Medical Assistance §1902(e)(1)
  Spousal Support Transitional §1931(c)(1), 42 CFR 435.115(f)
  Parents and other Caretaker Relatives 42 CFR 435.110
  Pregnant Women 42 CFR 435.116
  Coverage Infants and Children under age 19 42 CFR 435.118
  Former Foster Care Children §1902(a)(10)(A)(i)(IX), 42 CFR 435.150
  Independent Foster Care Adolescents §1902(a)(10)(A)(ii)(XVII), 42 CFR 435.226

Medicaid for Breast and Cervical Cancer §1902(a)(10)(A)(ii)(XVIII)
Reasonable Classification Children Under 21 §1902(a)(10)(A)(ii)(I) and (IV), 42 CFR 435.222
Adoption Assistance and Foster Care Children §1902(a)(10)(A)(i)(I), §473(b)(3), 42 CFR 435.145
Children with Non-IV-E Adoption Assistance §1902(a)(10)(A)(ii)(VIII), 42 CFR 435.227
SSI Recipient §1902(a)(10)(A)(i)(ll)
Pickle Group §1939(a)(5)(E), 42 CFR 435.135
Disabled Adult Children §1634(c) , §1935
Disabled Widow(er) §1634(b), §1935, 42 CFR 435.137
Early Aged Widow(er) §1634(d), §1935, 42 CFR 435.138
Medicaid Buy-In (MBI) §1902(a)(10)(A)(ii)(XIII)
Medicaid Buy-In for Children (under age 19) §1902(a)(10)(A)(ii)(XIX), §1902(cc)(1)

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

- ○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- ◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

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

Check each that applies:

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

Select one:

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

Specify percentage: [ ]

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

Specify dollar amount: [ ]

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

Select one:

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

Specify percentage amount: [ ]

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

○ **SSI standard**

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

(*select one*):

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

  Specify the percentage:

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

  Specify dollar amount:

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

  Specify percentage:

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

  Specify:

- ○ **The following dollar amount**

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

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

  Specify:

- ○ **Other**

  Specify:

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

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

  Specify:

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

  - ○ **SSI standard**
  - ○ **Optional State supplement standard**
  - ○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

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

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

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

Specify:

○ **Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:

- ○ **The following dollar amount:**

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

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

  Specify formula:

- ○ **Other**

  Specify:

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

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

   i. **Minimum number of services.**

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

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

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

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

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

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

Specify the entity:

- ○ **Other**

Specify:

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

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

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

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

DADS assigns the level of care based on the Intellectual Disability/Related Condition Assessment submitted by the case manager. The Intellectual Disability/Related Condition Assessment includes all factors that are assessed in evaluating a level of care determination: diagnostic information that includes age of onset of the qualifying conditions, names of qualifying conditions, the appropriate International Classification of Diseases-9 codes, the name of adaptive behavior assessment tool, and the adaptive behavior level.

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

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

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

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

The case manager or the nurse employed by the provider completes the level of care assessment for an individual and submits the assessment to DADS for review and approval. Based on the assessment information submitted, DADS staff authorize or deny the assignment of level of care and notify the case manager or nurse in writing of the decision. If the level of care is denied by DADS, the DBMD provider must notify the individual of the denial, his or her right to request a fair hearing, and the process for requesting a fair hearing. With the exception of a physician's signature on the level of care assessment form, the process for reevaluation of level of care is the same as an initial evaluation.

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

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**
  Specify the other schedule:

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

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

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

DADS requires the DBMD provider agencies to annually resubmit the level of care assessment along with the annual service plan. DADS reviews each level of care assessment for accuracy. If DADS discovers errors in submission, the DBMD provider agency is notified and instructed to correct the errors. If the DBMD provider does not submit a level of care reassessment prior to the expiration of the previously approved level of care, DADS requires the DBMD provider to submit the level of care reassessment as soon as possible after the expiration. However, if granted, reinstatement will only be effective for up to 180 calendar days before the date DADS receives the current Form 8578, or the first day of the new IPC period, whichever is more recent. DADS does not reimburse a provider for services provided during the time DADS has not approved the level of care assessment.

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

DADS also monitors and reviews the level of care effective periods during on-site monitoring visits to ensure timely resubmission to DADS.

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

Records of evaluations and re-evaluations of level of care are maintained by DADS and by the DBMD provider.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
B.a.1 Number and percent of individuals whose initial Level of Care was completed prior to the receipt of services. Numerator: Number of new enrollees whose Level of Care was completed prior to receipt of first service. Denominator: Total number of new enrollees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DBMD Database; DADS Quality Assurance and Improvement Datamart

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
B.b.1 Number and percent of individuals for whom level of care is reassessed annually. N: Number of enrolled individuals whose level of care is reassessed annually D: Total number of enrolled individuals

Data Source (Select one):
Other
If 'Other' is selected, specify:
DBMD Database; DADS Quality Assurance and Improvement Datamart

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
DBMD Database; Quality Assurance and Improvement Datamart

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
One hundred percent of level of care submissions are reviewed by the Department of Aging and Disability Services through desk reviews. DADS staff who are qualified intellectual disability professionals review the assessment information used to determine level of care and assure the accuracy of the level of care value for every individual in the DBMD waiver program.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DADS Access and Intake staff who are qualified intellectual disability professionals review the assessment information used to determine level of care and assure the accuracy of the level of care value for every individual in the DBMD waiver program. DADS returns any level of care forms that are not completed correctly to the provider for revision, and is responsible for ensuring that the returned level of care forms are corrected when errors are identified or that a denial is sent for an invalid level of care.

DADS Community Services Contracts monitoring includes a review of the case records to ensure each individual in the sample has documentation of level of care. This monitoring considers whether the level of care forms are signed by a physician, were approved by DADS Access and Intake staff, and that the level of care forms and supporting documentation were submitted to DADS within the required timeframes. Monitoring also considers if annual level of care forms were completed during the reassessment service planning team meeting and submitted to DADS within the required timeframes.

Technical assistance is shared with providers throughout the monitoring reviews. The monitoring review culminates in an exit conference, during which the provider is informed of all findings and is given the opportunity to ask questions. Further technical guidance related to the findings is provided during the exit conference. If the findings necessitate further action, DADS Community Services Contracts staff will refer the provider to the Sanction Action Review Committee, which is responsible for determining what further action, if any, is needed. These actions may include, among others, requiring the provider to submit a corrective action plan. If a corrective action plan is requested from the provider, the provider is informed that they may contact DADS staff with questions or requests for clarification of what constitutes an acceptable corrective action plan. This provides further opportunity for the provider to receive technical assistance relating to the specific area of deficiency. Upon submittal, DADS reviews the corrective action plan and either approves or, if the submitted plan does not include all of the required elements, requests revisions and resubmittal.

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

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

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

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

During the initial meeting with an individual, the case manager informs the individual of services available through DBMD and of any alternatives available, including the choice of institutional care versus home and community-based waiver services. The freedom of choice form is the Waiver Program Verification of Freedom of Choice form. The individual or legally authorized representative signs the form during the initial meeting to indicate he or she chooses waiver services over institutional care. During the initial meeting and annually, the provider case manager addresses living arrangements and choice of providers as well as available third party resources.

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

The forms are maintained by DADS and by the DBMD provider in the case record.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The Executive Staff Office, Support Services Coordination Unit, assists the program areas in obtaining translations into other languages and interpreter services (face-to-face or over-the-phone) through a number of third-party vendors for DADS.

DADS Communications Office, Language Services Unit provides the following: translation of written materials from English to Spanish or vice versa for state office and the regions; review and evaluation of Spanish translations that were prepared elsewhere; proofreading translated copy to ensure accuracy; translating correspondence sent by individuals to state

office; providing voice talent for audio and video productions; coordinating translation and interpretation for languages other than Spanish.

Appendix C: Participant Services

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

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:
Home and community support services agency
Provider Qualifications
License *(specify)*:
Licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97
Certificate *(specify)*:

Other Standard *(specify)*:
The case manager must meet one of the following criteria:

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

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

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

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

Verification of Provider Qualifications
Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

Contracts staff may conduct a follow-up review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a DBMD provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and

services rendered are conducted according to the priority of the allegations.

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope)*:
Provides individuals assistance with acquiring, retaining, or improving the self-help, socialization, and adaptive skills necessary to live successfully in the community and participate in home and community life. Day habilitation provides the individual with individualized activities in environments designed to foster the development of skills and behavior supportive of greater independence and personal choice consistent with achieving the outcomes identified in the individual's service plan. Activities are also designed to reinforce therapeutic outcomes targeted by other waiver services, school, or other support providers.

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

This service includes transportation necessary for the individual's participation in day habilitation activities, such as shopping, swimming, going to the park, or other community activities.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Day habilitation may not be provided to an individual at the same time employment assistance, supported employment, residential habilitation, 24-hour assisted living or respite is provided.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:
Agency

Provider Type:
Home and community support services agency
Provider Qualifications
License *(specify):*
Licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.
Certificate *(specify):*

Other Standard *(specify):*
The day habilitation provider must be 18 years of age or older and have:

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

The provider must be fluent in the communication methods used by the individual or have the ability to become fluent in the communication methods used by the individual within three months after being assigned to that individual. The provider of day habilitation must complete orientation and training as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, §42.403. If providing transportation, the provider of day habilitation must have a valid Texas driver's license with proof of insurance. Tasks delegated by a registered nurse must be performed in accordance with state law.
Verification of Provider Qualifications
Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

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

DADS Regulatory Services licenses home and community support services agencies, and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission or Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission or Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS

Regulatory Services coordinates with the Center for Medicare and Medicaid Services prior to initiating a complaint investigation.

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Payment will not be made for the routine care and supervision that a family member is legally obligated to provide or for activities or supervision for which a payment is made by a source other than Medicaid.

This service does not include payment for room or board and may not be provided at the same time that respite, day habilitation, employment assistance, supported employment, or licensed assisted living or licensed home health assisted living is provided.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer directed services direct service provider
Agency	Home and community support services agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Individual

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

Certificate *(specify):*

Other Standard *(specify):*
The residential habilitation provider must be 18 years of age or older and have:

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

In the consumer directed services option, the residential habilitation provider must not be the legal guardian or the spouse of the legal guardian. The consumer directed services direct service provider must be fluent in the communication methods used by the individual or have the ability to become fluent in the communication methods used by the individual within three months after being assigned to the individual. The consumer directed services direct service provider must complete orientation and training as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, §42.403. If providing transportation, the provider of residential habilitation must have a valid Texas driver's license with proof of insurance. Tasks delegated by a registered nurse must be performed in accordance with state law
Verification of Provider Qualifications
Entity Responsible for Verification:
Individual employer or legally authorized representative
Financial management services agency
DADS
Frequency of Verification:
Prior to hire by the individual-employer or the legally authorized representative and financial management services agency.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:
Home and community support services agency
Provider Qualifications
License *(specify):*
The agency must be licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.
Certificate *(specify):*

Other Standard *(specify):*

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

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

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Respite is provided on a short-term basis to address a need caused by the absence or need for relief of persons normally providing care for the individual. This service must not be provided by the individual's spouse or a paid caregiver of residential habilitation with whom the individual resides. This service provides the individual with assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of behavioral support or therapy activities; assistance with medications and the performance of tasks delegated by a registered nurse in accordance with state law; and supervision of the individual's safety and security. This service includes activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services, social interaction and participation in leisure activities, and daily and functional living skills.

Respite may be provided in the following locations: the individual's home or place of residence, the private residence of the respite provider, an intermediate care facility, an assisted living home, or a camp accredited by the American Camping Association.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Intermediate care facility
Agency	Home and community support services agency
Agency	Camp
Agency	Assisted living home
Individual	Consumer directed services direct service provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Intermediate care facility

Provider Qualifications

License *(specify)*:

Licensed by DADS as an intermediate care facility in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 90.

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each

new contract is monitored within the first 12 months of the contract and every two years thereafter.

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

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

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Home and community support services agency
Provider Qualifications
License *(specify):*
Title 40 of the Texas Administrative Code, Part 1, Chapter 97
Certificate *(specify):*

Other Standard *(specify):*
The home and community support services agency employee providing respite must be 18 years of age or older and have:

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

the individual.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

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

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

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Camp

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must be accredited by the American Camping Association and have experience serving individuals with disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

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

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

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:
Assisted living home

Provider Qualifications

License *(specify):*
Licensed as a home and community support services agency in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DADS

Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

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

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

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

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

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

Certificate *(specify)*:

Other Standard *(specify)*:
The consumer directed services direct service provider must be at least 18 years of age or older and have:

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

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Individual-employer or legally authorized representative
Financial management services agency
Frequency of Verification:
The financial management services agency and the individual-employer verify that each potential employee meets the required qualifications prior to being hired by the individual-employer.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home and community support services agency
Individual	Consumer directed services direct service provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
Home and community support services agency
Provider Qualifications
License *(specify)*:
Must be licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.
Certificate *(specify)*:

Other Standard *(specify)*:
The provider must be at least 18 years of age, not be the individual's legally responsible person, and satisfy one of these options:
Option 1:
- have a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and

- one year's paid or upaid experience providing employment services to people with disabilities.
Option 2:
- have an associate's degree in rehabilitation, business, marketing, or a related human services field; and
- two years' paid or upaid experience in providing employment services to people with disabilities.
Option 3:
- have a high school diploma or Certificate of High School Equivalency (GED credentials); and
- three years' paid or unpaid experience providing employment services to people with disabilities.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

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

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

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

Service Type: Statutory Service
Service Name: Supported Employment

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

Certificate *(specify)*:

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

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

Under the consumer directed services option, the provider cannot be the participant's legal guardian or the spouse of the legal guardian.
Verification of Provider Qualifications
Entity Responsible for Verification:
Individual-employer or legally authorized representative
Financial management services agency
DADS
Frequency of Verification:
For individual providers, the financial management services agency and the individual-employer or legally authorized representative verify that each potential employee meets the required qualifications prior to being hired by the individual-employer.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Prescribed Drugs

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope)*:

Provides unlimited prescription medications to individuals enrolled in the waiver who are eligible for both Medicaid and Medicare (dually eligible). An individual who is dually eligible must obtain prescribed medications through the Medicare Prescription Drug Plan or through the Texas Medicaid State Plan (for certain medications excluded from Medicare), before using the waiver to obtain the medications. Individuals who are not dually eligible for Medicare and Medicaid and are receiving acute care services through managed care will receive unlimited prescription medications through their managed care plan. Children (under 21 years) will continue to have access to unlimited prescriptions through state plan Medicaid.

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Pharmacies holding a Medicaid Provider Agreement—Vendor Drug with HHSC
Provider Qualifications
License *(specify)*:
The pharmacy must be licensed by the Texas State Board of Pharmacy under Title 22 of the Texas Administrative Code, Part 15, Chapter 291.
Certificate *(specify)*:
Other Standard *(specify)*:
Must hold Vendor Drug Provider Agreement with HHSC.
Verification of Provider Qualifications
Entity Responsible for Verification:
Texas State Board of Pharmacy
Frequency of Verification:
Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Supports for Participant Direction
The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
Support for Participant Direction:
Financial Management Services
Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

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

- [ ] **Legally Responsible Person**

☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial management services agencies

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Financial management services agencies
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

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

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

The provider employed by the financial management services agency must not be the individual's legal guardian; the spouse of the individual's legal guardian; the individual's designated representative; or the spouse of the individual's designated represenative.

Verification of Provider Qualifications
Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS monitors financial management services agencies at least every three years. Financial management services agencies are monitored more frequently if the need is indicated or if there is a complaint filed against the financial management services agency. A key part of that monitoring is

to ensure that the financial management services agency has verified that each potential participant employer's service provider meets the required qualifications prior to being hired by the participant employer. As a result of reviews, DADS will recoup the financial management services payment and any payments for providers who were unqualified at the time they provided the service. Findings from monitoring visits and complaint investigations result in a corrective action plan and go to a Sanction Action Review Committee to determine if actions should be taken against the financial management services agency provider, including consumer hold, vendor hold and termination.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Support Consultation

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Support consultation offers practical skills training and assistance to enable an individual or his or her legally authorized representative to successfully direct those services the individual or the legally authorized representative elects to self-direct. This service is provided by a certified support advisor, and includes skills training related to recruiting, screening, and hiring workers; preparing job descriptions; verifying employment eligibility and qualifications; completion of documents required to employ an individual; managing workers; and development of effective back-up plans for services considered critical to the individual's health and welfare in the absence of the regular provider or an emergency situation. Skills training involves such activities as training and coaching the individual or his or her legally authorized representative regarding how to write an ad, how to interview potential job candidates, and role-play to prepare to interview potential employees. In addition, the support advisor assists the individual or his or her legally authorized representative to determine staff duties, to orient and instruct staff in duties and to schedule staff. Support advisers also assist the individual or his or her legally authorized representative with activities related to the supervision, performance evaluation, and discharge of staff. This service provides sufficient information and assistance to ensure that individuals and their representatives understand the responsibilities involved with consumer direction. Support consultation does not address budget, tax, or workforce policy issues. The State defines support consultation as an optional service that is provided by a support advisor and provides a level of assistance and training beyond that provided by the consumer directed services agency through financial management services. Support consultation helps an individual or his or her legally authorized representative to meet the required employer responsibilities of the consumer directed services option and to successfully deliver program services. Support consultation may be provided by a certified support advisor associated with a financial management services agency selected by the individual or his or her legally authorized representative or by an independent certified support advisor hired by the individual or his or her legally authorized representative.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

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

Certificate *(specify):*
Provider must have a Support Advisor certificate issued by DADS to indicate successful completion of required training conducted or approved by DADS.
Other Standard *(specify):*
The direct service provider of support consultation must:
-be at least 18 years old;
-have a high school diploma or Certificate of High School Equivalency (GED credentials);
-have documentation of attendance and completion of initial training required by and conducted or authorized by DADS; and
-complete any ongoing training if required by and conducted or authorized by DADS.

The support advisor only provides support consultation to the individual.

The support advisor cannot be the:

-individual's spouse;
-individual's legal guardian;
-spouse of individual's legal guardian;
-individual's designated representative; or
-spouse of the individual's designated representative.

The support advisor must complete initial and periodic training provided by the qualified individual.

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Individual-employer or legally authorized representative
Financial management services agency
DADS
Frequency of Verification:
Financial management services agency and the individual-employer prior to completing the service agreement. DADS verifies at a minimum every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Adaptive Aids and Medical Supplies

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

An adaptive aid is provided for a specific individual and becomes the exclusive property of that individual. The individual's service planning team must authorize all adaptive aids. Items must be authorized by the service planning team based upon written evaluations and recommendations by the individual's physician, a licensed occupational or physical therapist, a psychologist, licensed psychological associate, dentist, optometrist, ophthalmologist, a registered nurse, a licensed dietician, a licensed audiologist, orientation and mobility specialist, or speech/language pathologist qualified to assess the individual's need for the specific adaptive aid. The written evaluation and recommendation must document the necessity and appropriateness of the adaptive aid to meet the specific needs of the individual.

Adaptive aids are limited to the following, including repair and maintenance not covered by warranty:

-Lifts
-Other modifications/additions to primary transportation vehicles
-Respiratory aids
-Sensory adaptations
-Mobility aids
-Positioning devices
-Environmental control units
-Medically necessary supplies or equipment
-Communication aids (including batteries)
-Adaptive or modified equipment for activities of daily living
-Safety devices

-Temporary lease/rental of medically necessary durable medical equipment to allow for repair, purchase, replacement of essential support system.

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

The maximum amount of funds available for adaptive aids is $10,000 per individual per service plan year. Adaptive aids are provided under this waiver when no other financial resource for such aids is available or when other available resources have been used. Individuals who are under 21 years of age must purchase adaptive aids through the Texas Health Steps--Comprehensive Care Program (EPSDT) before purchasing adaptive aids through this waiver. Excluded are those items and supplies which are not of direct medical or remedial benefit to the individual and items and supplies that are available to the individual through the Medicaid state plan, other governmental programs, or private insurance.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home and community support services agency

Provider Qualifications

License *(specify)*:

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

Certificate *(specify)*:

Other Standard *(specify)*:

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

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

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assisted Living

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

Assisted living may also include assistance with health care maintenance and medication administration provided within the scope of state law, and non-medical transportation as specified in the service plan. Transportation provided within the assisted living service is above and beyond the scope of transportation through the state plan service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Separate payment will not be made for respite, residential habilitation, transition assistance services, or chore services. On days an individual receives 24-hour assisted living, separate payment will not be made for day habilitation. When day habilitation is needed, services are claimed as 18-hour assisted living. This prevents duplication of services. Separate payment will not be made for 24-hour skilled nursing care.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home and community support services agency
Agency	Assisted living facility

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

Service Type: Other Service
Service Name: Assisted Living

Provider Category:
Agency
Provider Type:
Home and community support services agency
Provider Qualifications
License *(specify):*
Licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.
Certificate *(specify):*

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

The provider must be fluent in the communication methods used by the individual or have the ability to become fluent in the communication methods used by the individual within three months after being assigned to the individual. The provider must complete orientation and training as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, §42.403. If providing transportation, the provider must have a valid Texas driver's license with proof of insurance. Tasks delegated by a registered nurse must be performed in accordance with state law.
Verification of Provider Qualifications
Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

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

DADS Regulatory Services licenses home and community support services agencies, and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission or Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission and the Community Health

Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission or Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with the Center for Medicare and Medicaid Services prior to initiating a complaint investigation.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living

Provider Category:
Agency
Provider Type:
Assisted living facility
Provider Qualifications
License *(specify):*
Homes in which four to six individuals reside must be licensed as an assisted living facility under Title 40 of the Texas Administrative Code, Part 1, Chapter 92.
Certificate *(specify):*

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

The provider must be fluent in the communication methods used by the individual or have the ability to become fluent in the communication methods used by the individual within three months after being assigned to the individual. The provider must complete orientation and training as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, §42.403. If providing transportation, the provider must have a valid Texas driver's license with proof of insurance. Tasks delegated by a registered nurse must be performed in accordance with state law.
Verification of Provider Qualifications
Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

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

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Audiology Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope)*:
Audiology provides assessment and treatment by licensed audiologists, and includes training and consultation with an individual's family members or other support providers.

The audiology service includes:

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Audiology Services

Provider Category:
Agency
Provider Type:
Home and community support services agency
Provider Qualifications
License *(specify)*:
Licensed by DADS as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

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

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

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

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavioral Support

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Behavioral support provides specialized interventions that assist an individual to increase adaptive behaviors to replace or modify maladaptive or socially unacceptable behaviors that prevent or interfere with the individual's inclusion in home and family life or community life, with a particular emphasis on communication as it affects behavior. The service includes assessment and analysis of assessment findings of the behavior(s) to be targeted so that an appropriate behavior support or communication plan may be designed; development of an individualized behavioral support plan consistent with the outcomes identified in the individual's service plan; training of and consultation with family members or other support providers on the implementation of the behavioral support plan or revisions of the plan; monitoring and evaluation of the success of the behavioral support plan implementation; and modification, as necessary, of the behavioral support plan based on documented outcomes of the plan's implementation. When appropriate, the person providing behavioral support educates the individual in the purpose/objectives, methods and documentation requirements of the plan. The service may also include counseling with and educating a participant's family, friends or other service providers about interacting with a participant whose behaviors may interfere with independent living.

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

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support

Provider Category:
Agency
Provider Type:
Home and community support services agency
Provider Qualifications
License *(specify)*:
Licensed by DADS as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.
Certificate *(specify)*:

Other Standard *(specify)*:
-Psychologist (Texas Occupations Code Chapter 501);
-Psychological Associate (Texas Occupations Code Chapter 501);
-Certification as Behavior Analyst by the Behavior Analyst Certification Board, Inc.;
-Behavior Communication Specialist with a Masters or Ph.D degree in special education, psychology, or a related human services discipline, and three years of experience providing direct services to individuals who have deafblindness; or
-Bachelors degree in psychology or special education and seven years of experience providing direct services to individuals who have deafblindness and multiple disabilities.

Verification of Provider Qualifications
Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

Contracts staff may conduct a follow-up review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a DBMD provider for failure to maintain provider qualifications. DADS levies appropriate provider

agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Chore Service

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Services needed to maintain the individual's home as a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, securing loose rugs and tiles, moving heavy items or furniture in order to provide safe access and egress.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
These services will be provided only in cases when neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and when no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for the provision of the service. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Service

Provider Category:
Agency
Provider Type:
Home and community support services agency
Provider Qualifications
License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

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

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Dental Treatment

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

This service includes the following two elements:

(A) Routine preventive, therapeutic, orthodontic treatment, and emergency dental treatment, to include:
1. Emergency dental treatment: Those procedures necessary to control bleeding, relieve pain, and eliminate acute infection; operative procedures that are required to prevent the imminent loss of teeth; and treatment of injuries to the teeth or supporting structures.
2. Preventive dental treatment: Examinations, X-rays, cleanings, sealants, oral prophylaxes, and topical fluoride applications.
3. Therapeutic dental treatment: Treatment that includes, but is not limited to: fillings, scaling, extractions, crowns, pulp therapy for permanent and primary teeth; restoration of carious permanent and primary teeth; maintenance of space; and limited provision of removable prostheses when masticatory function is impaired, when an existing prosthesis is unserviceable, or when aesthetic considerations interfere with employment or social development.
4. Orthodontic dental treatment: Procedures that include treatment of retained deciduous teeth; cross-bite therapy; facial accidents involving severe traumatic deviations; cleft palates with gross malocclusion that will benefit from early treatment; and severe, handicapping malocclusions affecting permanent dentition with a minimum score of 26 as measured on the Handicapping Labio-lingual Deviation Index.
(B) Sedation necessary to perform dental treatment including non-routine anesthesia, e.g., intravenous sedation,

general anesthesia, or sedative therapy prior to routine procedures. Sedation does not include administration of routine local anesthesia only.

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

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

Cosmetic orthodontia is excluded from the dental treatment service.

Dental treatment is provided through the waiver when no other financial resources for the service are available or when other available resources have been exhausted. Individuals who are under 21 years of age must access dental treatment benefits through the Texas Health Steps--Comprehensive Care Program (EPSDT) before dental treatment may be provided through the waiver.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dental Treatment

Provider Category:

Agency

Provider Type:

Home and community support services agency

Provider Qualifications

License *(specify)*:

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

The person providing dental treatment must be licensed as a dentist under Texas Occupations Code, Chapter 251.

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

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

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Dietary Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope)*:
Dietary services assist individuals in meeting their basic and/or special therapeutic nutritional needs. Dietary services are especially important to ensure and maintain the health of persons on modified diets required by a disability and those requiring enteral or parenteral nutrition regimens.

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

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

In the Texas state plan, dietician services are provided only to children or to adults with specific high-risk conditions as defined in Title V. Services provided in the waiver are outside the scope of the state plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Dietary services are provided through the waiver when no other financial resources are available or when other available resources have been exhausted. Individuals who are under 21 years of age must access benefits through the Texas Health Steps--Comprehensive Care Program (EPSDT) before dietary services may be provided through the waiver.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietary Services

Provider Category:
Agency
Provider Type:
Home and community support services agency
Provider Qualifications
License *(specify):*
Licensed by DADS as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

The dietician must be licensed under Title 22 of the Texas Administrative Code, Part 31, Chapter 711.
Certificate *(specify):*

Other Standard *(specify):*
The home and community support services agency must hire a person or sub-contractor who complies with the requirements for delivery of nutritional services in accordance with the service plan, which includes the dietician duties and credentialing.
Verification of Provider Qualifications
Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

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

DADS Regulatory Services licenses home and community support services agencies, and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission or Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all

home and community support service agencies, including those that are accredited by the Joint Commission or Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with the Center for Medicare and Medicaid Services prior to initiating a complaint investigation.

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Employment Assistance

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

A provider of employment assistance may bill for such services as: (1) transporting the individual to and from the work site, (2) activities related to supporting the individual to be self-employed, work from home, or perform in a work setting, and (3) participating in service planning team meetings.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Documentation is maintained in the individual's record that the service is not available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.).

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home and community support services agency
Individual	Consumer directed services direct service provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Assistance

Provider Category:
Agency
Provider Type:
Home and community support services agency
Provider Qualifications

License *(specify):*
Licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.
Certificate *(specify):*

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

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

DADS Regulatory Services licenses home and community support services agencies, and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission or Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority

of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission or Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with the Center for Medicare and Medicaid Services prior to initiating a complaint investigation.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Assistance

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

Certificate *(specify)*:

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

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

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

Individual employer or legally authorized representative
Financial management services agency
DADS
Frequency of Verification:
For individual providers, the financial management services agency and the individual-employer verify that each potential employee meets the required qualifications prior to being hired by the individual-employer.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Intervener

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home and community support services agency
Individual	Consumer directed services direct service provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Intervener

Provider Category:
Agency

Provider Type:
Home and community support services agency

Provider Qualifications

License *(specify)*:
Licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

Certificate *(specify)*:

Other Standard *(specify)*:
There are four levels of intervener qualifications.

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

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

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

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

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

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Intervener

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

Certificate *(specify):*

Other Standard *(specify):*
There are four levels of intervener qualifications.

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

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

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

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

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

If providing transportation, all four levels of intervener must have a valid Texas driver's license with proof of insurance.
Verification of Provider Qualifications
Entity Responsible for Verification:

Individual employer or legally authorized representative
Financial management services agency
DADS
Frequency of Verification:
For individual providers, the financial management services agency and the individual-employer verify that each potential employee meets the required qualifications prior to being hired by the individual-employer.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Minor Home Modifications

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

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

All minor home modifications must be authorized by the individual's service planning team. Any modification or combination of modifications must be authorized by the team based on prior written evaluations and recommendations from a professional qualified to assess the individual's need for the specific minor home modification. The written evaluation must document the necessity and appropriateness of the minor home modification to meet the specific needs of the individual.

Minor home modifications must be provided in accordance with applicable state and local building codes and include installation, maintenance, and repair not covered by warranty. The service includes the following categories:

-Construction or repair of wheelchair ramps and landings, or both to meet ADA specifications
-Protective awnings over ramps
-Modifications to bathroom facilities
-Modifications to kitchen facilities
-Specialized accessibility and safety adaptations

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The maximum lifetime expenditure for this service is $10,000. After the lifetime maximum is reached $300 is allowed per service plan year, per individual, for repairs, replacement or additional modifications. Minor home modifications cannot be provided in alternative living arrangements.

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Minor Home Modifications

Provider Category:
Agency
Provider Type:
Home and community support services agency
Provider Qualifications

License *(specify):*
Licensed by DADS as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.
Certificate *(specify):*

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

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

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

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

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

Service Type:

Other Service

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

Service Title:

Nursing

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

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

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

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

Nursing services are provided through the waiver when no other financial resources for the service are available or when other available resources have been exhausted. Individuals who are under 21 years of age must first access nursing services through the Texas Health Steps--Comprehensive Care Program (EPSDT).

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing

Provider Category:
Agency
Provider Type:
Home and community support services agency
Provider Qualifications
License *(specify)*:
Licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

The nurse must be licensed by the Texas Board of Nursing under Title 22 of the Texas Administrative Code, Part 11, Chapter 217.
Certificate *(specify)*:

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

The licensed vocational nurse must practice under the supervision of a registered nurse licensed to practice in the State.
Verification of Provider Qualifications
Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

Contracts staff may conduct a follow-up review for providers that do not meet an acceptable

compliance level during routine reviews. Contracts staff responds to complaints received against a DBMD provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Occupational Therapy Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

Occupational therapy services are provided by an occupational therapist, or a licensed occupational therapy assistant under the direction of a licensed occupational therapist, within the scope of state licensure.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Occupational therapy services are provided through the waiver when no other financial resources for the service are available or when other available resources have been exhausted. Individuals who are under 21 years of age must first access occupational therapy benefits through the Texas Health Steps--Comprehensive Care Program (EPSDT) before occupational therapy may be provided through the waiver.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Occupational Therapy Services

Provider Category:

Agency

Provider Type:
Home and community support services agency
Provider Qualifications

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

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

Other Standard *(specify):*
The home and community support services agency must hire a person or sub-contractor who complies with the requirements for delivery of occupational therapy services, in accordance with the service plan, which includes occupational therapist and occupational therapist assistant duties and credentialing.

Verification of Provider Qualifications

Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

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

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

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

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

Service Type:

Other Service

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

Service Title:

Orientation and Mobility

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope)*:

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Orientation and Mobility

Provider Category:
Agency
Provider Type:
Home and community support services agency
Provider Qualifications
License *(specify):*
Licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.
Certificate *(specify):*
Providers of orientation and mobility must be certified in orientation and mobility by the Academy for the Certification of Vision Rehabilitation and Education Professionals, or by The National Orientation and Mobility Certification (NOMC) through the National Blindness Professional Certification Board (NBPCB.)
Other Standard *(specify):*
Providers of orientation and mobility must hold a bachelors or Masters degree in orientation and mobility.
Verification of Provider Qualifications
Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

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

DADS Regulatory Services licenses home and community support services agencies, and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission or Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. Upon license renewal, DADS

Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission or Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with the Center for Medicare and Medicaid Services prior to initiating a complaint investigation.

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Physical Therapy Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Physical therapy services include: screening and assessment; developing therapeutic treatment plans; providing direct therapeutic intervention; recommending adaptive aids; training and assisting with adaptive aids; consulting with other providers and family members; and participating on the service planning team, when appropriate.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Physical therapy services are provided through the waiver when no other financial resources for physical therapy services are available or when other available resources have been exhausted. Individuals who are under 21 years of age must access therapy benefits through the Texas Health Steps--Comprehensive Care Program (EPSDT) before physical therapy services may be provided through the waiver.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physical Therapy Services

Provider Category:
Agency
Provider Type:
Home and community support services agency
Provider Qualifications
License *(specify):*
Licensed by DADS as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

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

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

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

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Speech, Hearing, and Language Therapy Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

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

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

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

Speech, hearing, and language therapy services are provided through the waiver when no other financial resources for speech, hearing, and language therapy services is available or when other available resources have been exhausted. Individuals who are under 21 years of age must access speech, hearing and language therapy

services through the Texas Health Steps--Comprehensive Care Program (EPSDT) before speech, hearing and language therapy services may be provided through the waiver.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Home and community support services agency

Provider Qualifications

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

The speech-language pathologist and assistant speech-language pathologist must be licensed under Title 22 of the Texas Administrative Code, Part 32, Chapter 741.

Certificate *(specify)*:

Other Standard *(specify)*:
The home and community support services agency must hire a person or sub-contractor who complies with the requirements for delivery of speech, hearing, and language therapy services in accordance with the service plan, which includes the speech-language pathologist and assistant speech-language pathologist duties and credentialing.

Verification of Provider Qualifications

Entity Responsible for Verification:
DADS

Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

Contracts staff may conduct a follow-up review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a DBMD provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on

the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transition Assistance Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

Room and board are not allowable expenses.

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

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

To be eligible to receive transition assistance services the individual must be a resident of a Texas nursing facility or intermediate care facility who wishes to be discharged from that facility; be Medicaid eligible; and be determined eligible for DBMD services;
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Transition assistance services are one-time initial expenses for setting up a household that cannot exceed $2,500.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title

Provider Category	Provider Type Title
Agency	Agencies holding a transition assistance services provider agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Assistance Services

Provider Category:
Agency
Provider Type:
Agencies holding a transition assistance services provider agreement
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Transition assistance services agencies must meet requirements outlined in Title 40 of the Texas Administrative Code, Part 1, Chapter 62.

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

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

Verification of Provider Qualifications
Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS Community Services Contracts staff is responsible for conducting monitoring reviews every two years. DADS Community Services Contracts staff responds to complaints received against a contractor for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions/sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity.

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

Appendix C: Participant Services

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

b. **Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- [x] **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- [ ] **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- [ ] **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- [ ] **As an administrative activity.** *Complete item C-1-c.*

c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ( ) **No. Criminal history and/or background investigations are not required.**
- (•) **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Providers, individual-employers, and financial management services agencies must comply with the Texas Health and Safety Code, Chapter 250, by taking the following actions regarding individuals, contractors, and employees:

-Obtain Texas criminal history record information from the Texas Department of Public Safety that relates to an unlicensed applicant, volunteer, contractor, or employee whose duties would or do involve direct contact with an individual; and
-Refrain from employing or contracting with, or immediately discharge, a person who has been convicted of an offense that bars employment under Texas Health and Safety Code §250.006, or an offense that the provider or participant employer determines is a contraindication to the person's employment to contract to provide services to the individual.

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

Financial management services agencies, providers of self-directed services, and individual-employers must comply with rules in Title 40 of the Texas Administrative Code, Part 1, Chapter 41. These rules require a criminal history check before a person can become an employee, or a contractor. The financial management services agency is required to have verification of criminal history checks prior to finalizing the hiring process on behalf of the individual-employer.

Home and community support services agencies must comply with Title 40 of the Texas Administrative Code, Part 1, Chapter 97, by completing and maintaining documentation of criminal history checks. Assisted living facilities must comply with Title 40 of the Texas Administrative Code, Part 1, Chapter 92, by completing and maintain documentation of criminal history checks. Providers, financial management services agencies, and individual-employers are required to maintain documentation of the criminal history checks performed.

Providers must screen all employees and contractors for exclusion prior to hiring or contracting and on an

ongoing monthly basis by searching both the state and federal lists of excluded persons and entities. If any exclusion is discovered the provider must immediately report the findings to DADS.

DADS verifies that providers have conducted screening for exclusion and performed other applicable registry checks during the regulatory surveys. Non-licensed financial management services agencies are monitored at least every three years.

Regulatory boards (e.g., Texas Board of Nursing) conduct criminal background checks on licensed professionals and ensure during surveys that licenses are appropriate as part of the licensing process.

For volunteers, the home and community support services agencies must comply with Title 40 of the Texas Administrative Code, Part 1, Chapter 97, Subchapter C.

As part of on-site reviews of providers and financial management services agencies, DADS monitors if criminal history checks are conducted as required.

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

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

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

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

Providers, individual-employers, and financial management services agencies must comply with the Texas Health and Safety Code, Chapters 250 and 253, by taking the following action regarding applicants, contractors, and employees:

-Search the Nurse Aide Registry maintained by DADS in accordance with Texas Health and Safety Code, Chapter 250, and refrain from employing or contracting with, or immediately discharge, a person who is designated in the registry as having abused, neglected, or mistreated an individual of a facility or has misappropriated an individual's property; and

-Search the Employee Misconduct Registry maintained by DADS in accordance with Texas Health and Safety Code, Chapter 253, and refrain from employing or contracting with or immediately discharge, a person whose duties would or do involve direct contact with an individual, and who is designated in the registry as having abused, neglected, or exploited an individual or has misappropriated an individual's property.

Providers, individual-employers, and financial management service agencies are also required to perform Nurse Aide Registry and Employee Misconduct Registry checks on contractors.

Providers must screen all employees for exclusion prior to hiring and on an ongoing monthly basis by searching both the state and federal lists of excluded individuals and entities. If any exclusion is found it must immediately be reported.

DADS Regulatory Services staff that are involved in licensure, survey, and enforcement activities, as part of their reviews of providers, monitor if Nurse Aide Registry and Employee Misconduct Registry checks are conducted as required.

Providers, financial management services agencies, and individual-employers are required to maintain documentation of the Nurse Aide Registry and Employee Misconduct Registry checks performed.

Each individual who chooses self-direction must choose a financial management services agency that provides guidance and assistance to the individual with employer-related tasks. The financial management services

agency is required to have verification of registry checks prior to hiring on behalf of the individual.

During on-site reviews of providers and financial management services agencies, DADS monitors for completion of required registry checks.

For volunteers, the home and community support services agencies must comply with Title 40 of the Texas Administrative Code, Part 1, Chapter 97, Subchapter C.

Appendix C: Participant Services

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

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Assisted Living Facility	
Intermediate Care Facility	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

DBMD offers assisted living services in home settings serving four to six participants, which requires the provider to obtain and maintain an assisted living facility license. These small residential settings are located in community neighborhoods in family homes and are constructed with kitchen areas, living rooms, bedrooms with no more than two individuals per bedroom, and bathrooms. The individuals must have access to a telephone, a place for personal belongings and the ability to entertain guests. Assisted living facility services are driven by a service philosophy that emphasizes personal dignity, autonomy, independence, and privacy.

Texas further ensures a home and community based character is maintained in assisted living facilities through review and enforcement of licensure requirements found in Title 40 of the Texas Administrative Code, Part 1, Chapter 92, Subchapter G which include, but are not limited to, the following: Each resident in the assisted living facility has the right to:
-Participate in activities of social, religious, or community groups unless the participation interferes with the rights of others;
-Make his/her own choices regarding personal affairs, care, benefits, and services;
-Receive and send unopened mail;
-Unrestricted communication, including personal visitation with any person of the resident's choice, including family members and representatives of advocacy groups and community service organizations, at any reasonable hour;
-Make contacts with the community and to achieve the highest level of independence, autonomy, and interaction with the community of which the resident is capable;
-Unaccompanied access to a telephone at a reasonable hour or in case of an emergency or personal crisis;
-Privacy, while attending to personal needs and a private place for receiving visitors or associating with other residents;
-Retain and use personal possessions, including clothing and furnishings, as space permits;

-Determine his or her dress, hair style, or other personal effects according to individual preference; and
-Retain and use personal property in his or her immediate living quarters and to have an individual locked area (cabinet, closet, drawer, footlocker, etc.) in which to keep personal property.

DBMD offers respite in intermediate care facilities in which up to 6 individuals may reside. When receiving respite in an intermediate care facility, an individual has the right to:
- a normal residential environment;
- to communication and visits; and
- to possess personal property.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Orientation and Mobility	☐
Behavioral Support	☑
Nursing	☐
Dental Treatment	☐
Employment Assistance	☐
Supported Employment	☐
Residential Habilitation	☐
Transition Assistance Services	☐
Respite	☐
Day Habilitation	☑
Prescribed Drugs	☑
Minor Home Modifications	☐
Chore Service	☐
Financial Management Services	☐
Case Management	☑
Support Consultation	☐
Physical Therapy Services	☐
Adaptive Aids and Medical Supplies	☐
Speech, Hearing, and Language Therapy Services	☑
Occupational Therapy Services	☐
Intervener	☑
Audiology Services	☐
Assisted Living	☑
Dietary Services	☐

Waiver Service	Provided in Facility

Facility Capacity Limit:

Six individuals

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

N/A

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Intermediate Care Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Orientation and Mobility	☐
Behavioral Support	☐
Nursing	☐
Dental Treatment	☐
Employment Assistance	☐
Supported Employment	☐
Residential Habilitation	☐
Transition Assistance Services	☐
Respite	

Waiver Service	Provided in Facility
	☑
Day Habilitation	☐
Prescribed Drugs	☐
Minor Home Modifications	☐
Chore Service	☐
Financial Management Services	☐
Case Management	☐
Support Consultation	☐
Physical Therapy Services	☐
Adaptive Aids and Medical Supplies	☐
Speech, Hearing, and Language Therapy Services	☐
Occupational Therapy Services	☐
Intervener	☐
Audiology Services	☐
Assisted Living	☐
Dietary Services	☐

Facility Capacity Limit:

Six individuals

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

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

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

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

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

- ( ) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- (●) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

Reimbursement for waiver services provided to an individual by an individual's family member or guardian is subject to the following restrictions/conditions:

1. Payment will not be made for waiver services provided to an individual by the spouse of the individual.
2. Payment will not be made for assisted living provided to an individual by the individual's guardian or relative.
3. Payment will not be made for respite provided to an individual by a relative or guardian who lives with the individual and who is paid to provide residential habilitation to the individual.
4. Payment for residential habilitation and respite can be made to the parent/guardian of an individual who is over the age of 17.
5. Reimbursement for waiver services provided by a relative or guardian not prohibited above is allowed only for reasons that benefit the individual as determined and documented by the service planning team.
6. Payments will not be made for the routine care and supervision, which would be expected to be provided by a family member.

7. Following are the services which, if not self-directed, may be provided by a guardian or family member: day habilitation, residential habilitation, respite, supported employment, employment assistance, chore services, intervener, minor home modifications, and nursing.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

In order to obtain a DBMD provider agreement, a provider applicant must apply for such in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 49, Subchapter B, relating to Contracting for Community Care Services.

Information for obtaining a DBMD contract is provided by contacting the DADS Community Services Contracts Unit.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
C.a.1 Number and percent of newly enrolled licensed providers that initially met required contract and program standards and adhered to other standards prior

to furnishing waiver services. N: Number of newly enrolled licensed providers that met required contract and program standards and adhered to other standards prior to furnishing waiver services D: Number of newly enrolled licensed providers

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
C.a.2 Number and percent of monitored licensed providers that met required contract and program standards. N: Number of monitored licensed providers that met required contract and program standards D: Number of monitored licensed providers

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

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

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

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

Performance Measure:
C.b.1 Number and percent of new financial management services agencies who met initial qualifications. N: Number of new financial management services agencies who met initial qualifications. D: Number of new financial management services agencies.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
C.b.2 Number and percent of financial management services agencies who continue to meet contract requirements. N: Number of financial management services agencies who continue to meet contract requirements. D: Number of financial management services agencies monitored.

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

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C.c.1 Number and percent of providers for whom the State conducted training in accordance with State requirements and the approved waiver. N: Number of providers meeting provider training requirements D: Number of providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
DADS Contracts Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Biennially	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
DADS Community Services Contracts staff verifies that all potential providers meet the qualifications specified in the waiver prior to DADS awarding a provider agreement/contract.

Regulatory Services surveyors monitor the performance of licensed home and community support services agencies and assisted living facilities through surveys and inspections. Surveyors conduct follow-up surveys and inspections to ensure the provider has effectively implemented any corrective action plans required due to cited state violations. Home and community support services agencies that are not accredited by the Joint Commission or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. DADS Regulatory Services verifies upon license renewal that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Assisted living facilities are inspected annually. Home and community support services agencies and assisted living facilities licenses are valid for two years. The Regulatory Services survey includes observation of the care of individuals.

Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission or the Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with the Center for Medicare and Medicaid Services prior to initiating a complaint investigation.

DADS Community Services Contracts staff is responsible for conducting monitoring reviews of all DBMD providers. Monitoring reviews are conducted at least biennially. Community Services Contracts staff completes a readiness review six months after an initial provider agreement/contract has been awarded. Contract monitoring reviews are conducted at least every 24 months after the provider agreement/contract has been awarded. Community Services Contracts staff also responds to complaints received against a contractor for failure to maintain provider qualifications. The Community Services Contracts review includes observation of the individuals. In preparation for on-site provider reviews, Community Services Contracts staff:

- Selects a valid random sample of individuals receiving services;
- Retrieves information pertinent to the provider's operation from a database of complaints reported to DADS Community Services Contracts staff; and

- Reviews results of the provider's past performance during on-site reviews.

While on site, DADS Community Services Contracts staff gathers evidence of a provider's compliance with the waiver requirements as prescribed in program rules found in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, and with provider agreement/contract requirements through:

- Interviews with individuals and their legally authorized representatives or families;
- Interviews with providers; and
- Reviews of individual and provider records.

DADS Contract Oversight and Support area administers the Health and Human Services Contract Administration and Tracking System. The Health and Human Services Contract Administration and Tracking System is a custom-developed Health and Human Service Enterprise application with a consolidated database for contract information and reporting. On a monthly basis, DADS Community Services Contracts staff reports the complaint intake, complaint investigation findings, and contract and fiscal compliance monitoring results to Contract Oversight and Support for entry into the Health and Human Services Contract Administration and Tracking System. Contract Oversight and Support also enters information pertaining to contract actions and sanctions imposed against a contract. Through the Health and Human Services Contract Administration and Tracking System reporting features, information pertaining to contract expenditures, compliance, and overall history is available for analysis, trending and reporting by the Contract Oversight and Support unit.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DADS Regulatory Services requires a corrective action plan from home and community support services agencies for violations and deficiencies cited during a survey or investigation. In addition, staff may also impose enforcement actions for violations, including administrative penalties, denying approval for an initial license, suspending an existing license on an emergency basis and revoking a license. The severity of an administrative penalty is based on the severity of the violation, the history of previous violations and the hazard of the violation to the health or welfare of individuals. Surveyors conduct follow-up surveys and investigations to ensure the agency has effectively implemented any corrective action plan required due to cited state violations and federal deficiencies.

Technical assistance is shared with providers throughout the DADS Community Services Contracts review. If, during a contract monitoring review, a provider is discovered to not have submitted a service plan within the required timeframe or if a service plan is missing signatures, the provider agency is required to submit a corrective action plan to the Department of Aging and Disability Services. The corrective action plan must contain the following elements:

- The title of the person responsible for the action;
- A description of the action to be accomplished;
- The date the action will be implemented; and
- The action to ensure compliance.

If a corrective action plan is requested from the provider, the provider is informed that they may contact DADS staff with any questions or requests for clarification of what constitutes an acceptable corrective action plan. Upon submittal, DADS reviews the corrective action plan and either approves or, if the submitted plan does not include all of the required elements, requests revisions and resubmission of the plan. Providers are informed that their failure to ensure DADS receives an acceptable corrective action plan by the date specified by DADS may result in DADS taking adverse action against the provider, up to and including termination of the provider agreement/contract. DADS monitors the corrective action plan until the provider is in compliance.

DADS Community Services Contracts staff submits provider agreement/contract action recommendations to the Sanction Action Review Committee when a complaint investigation against a provider substantiates a reported allegation or Contracts staff recommend the provider receive a contract action/sanction greater than only a corrective action plan. Sanction Action Review Committee members review the monitoring review

results and, if applicable, review complaint investigation findings to ensure the circumstances support the recommended provider agreement/contract action. The Sanction Action Review Committee makes a decision on the appropriate action to take, including submission of a corrective action plan; placing a hold on individual referrals for new clients; placing a hold on provider payments; financial recoupment; involuntary contract termination; and debarment.

Results of each contract monitoring review are documented and recorded in an Access database maintained in the state office.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

DADS is still assessing settings compliance in accordance with our transition plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Individual Service Plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- [ ] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- [ ] **Licensed physician (M.D. or D.O)**
- [x] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [ ] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  Specify qualifications:

- [ ] **Social Worker**

  Specify qualifications:

- [ ] **Other**

  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. **Service Plan Development Safeguards.** *Select one:*

- ○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The service planning team process ensures that there is no conflict of interest when a provider who monitors and assists in development of the service plan also provides other direct services. All of the various team members contribute to development of the service plan based on the individual's interests, needs, strengths, weaknesses, likes and dislikes. The team assists in determining the types and units of services necessary for the plan.

During monitoring reviews, DADS monitors all DBMD provider agencies to ensure that the DBMD agency implements service planning requirements, including that the individual's needs are being met and that their service plan changes as their needs change.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The case manager assures that the individual and legally authorized representative participate in developing a personalized service plan that meets the individual's identified needs and service outcomes. The case manager supports the individual and legally authorized representative to set goals that address the needs identified during assessment. The case manager also educates the individual, legally authorized representative or both about service

delivery options and services available through the DBMD program that will contribute to goal achievement. The case manager informs the individual, and legally authorized representative of the following:

• eligibility criteria for participation in the DBMD program;
• the application and enrollment process;
• the individual's rights and responsibilities;
• the mandatory participation requirements;
• the services and supports provided by the DBMD program and the limits on those services and supports; and
• the reasons an individual's DBMD program services may be terminated.

The case manager assures that the individual, and family or legally authorized representative, as appropriate, can contact the case manager to secure information regarding services, supports and service delivery options; and can request to change the service plan due to changes in needs, goals or preferences. At least quarterly, the case manager meets with the individual, legally authorized representative or both and reviews the service plan and progress towards goals and service needs, including any changes which may have occurred since the last review. At least annually, the case manager presents information to the individual, legally authorized representative or both regarding available waiver services and supports, the available service delivery options, and the available DBMD provider agencies.

The service planning team consists of the individual, legally authorized representative, case manager, nurse or program director, and staff providing direct services. The individual, legally authorized representative or both may designate direct service staff to be involved in the service planning as well as invite other persons such as family members, friends or advocates.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The case manager initiates, coordinates, and facilitates the service planning process to assure that an individual's service plan addresses the needs as identified by the individual or legally authorized representative. The case manager, individual, and legally authorized representative, program director or nurse, direct service provider, and others (e.g., family, friends, advocates or others) as designated by the individual, legally authorized representative, or both comprise the service planning team. Unless there is documentation of a reason for a delay, the case manager must meet with the individual face-to-face within the first 30 calendar days of the date the provider is notified by DADS that they have been selected by the individual as the individual's DBMD program provider. The case manager must coordinate with the individual or legally authorized representative to schedule the service planning meeting.

As part of the initial face-to-face visit, formal assessments regarding health, level of functioning, level of care evaluation and specialized therapeutic interventions should be completed. Level of functioning is determined using the Related Conditions Eligibility Screening Instrument and the adaptive behavior level is determined by administering one of the following assessment tools:

• Inventory for Client and Agency Planning (ICAP);
• Scales of Independent Behavior (SIB-R);
• Vineland Adaptive Behavior Scales (VABS); or
• the American Association on Mental Deficiencies Adaptive Behavior Scales (AAMD).

As applicable, the service planning team also reviews the nursing, dental, or other medical assessments; therapy evaluations; social, psychological, or behavioral assessments; and orientation and mobility evaluations. Within ten business days after receipt of the signed level of care evaluation by the physician, the service planning team convenes to develop the initial service plan. Thereafter, when a need is identified, the service planning team meets to amend the plan. At least annually, the service planning team must review the service plan and initiate changes in the service plan in response to changes in the individual's needs and identified outcomes as documented in the service plan. The individual, legally authorized representative, or both must sign the plan to indicate understanding of, and agreement with, the plan.

The service planning team must document that the DBMD services in the service plan: are necessary for the individual to live in the community; are the most appropriate type and amount of services to meet the individual's needs; prevent admission to an institution; and are sufficient when combined with non-waiver resources to assure the individual's health and welfare in the community.

At a minimum, the service plan process and resulting plan must address the following:
(A) A description of the needs and preferences identified by the individual, legally authorized representative or both;
(B) A description of the services and supports the individual requires to continue living in a community-based setting;
(C) A description of the individual's current natural supports and non-DBMD services that will be or are available;
(D) A description of individual outcomes to be achieved through the DBMD services and justification for each service included in the service plan;
(E) Documentation that the type, frequency, and amount of each service component included in the service plan does not replace existing natural supports or non-DBMD sources for the service components for which the individual may be eligible; and
(F) A description of actions and methods to be used to reach identified service outcomes.

The case manager assures that the service plan process identifies and focuses on the desired outcomes and needs as identified by the individual, legally authorized representative, or both. The case manager supports the individual and legally authorized representative's participation in the process by encouraging the expression of preferences, goals, and ambitions, and providing education about the services available through the DBMD program, as well as through other non-waiver resources for which the individual may be qualified. In addition, formal assessments regarding health, level of functioning, and specialized therapeutic interventions are completed as the need is identified by the service planning team.

At enrollment, and at least annually, the case manager must present to the individual, legally authorized representative, or both information regarding available services and supports and the available service delivery options. The case manager must also inform the individual, legally authorized representative, or both that the case manager will assist in transferring the individual's DBMD services from one program provider to another program provider upon request from the individual. The case manager must assure the individual, legally authorized representative, or both are informed of how to contact the case manager.

The individual and legally authorized representative, case manager, and other team members work together to develop a service plan that integrates DBMD services and supports and non-waiver services so that the individual's goals may be achieved and services are complementary and not duplicative.

The service plan process must include a description of actions and methods to be used to reach identified service outcomes, projected completion dates, and entity or person(s) responsible for implementing the methodology. The service plan must specify the type and amount of each service to be provided to the individual, as well as services and supports to be provided by non-DBMD resources during the service plan year. At least quarterly and more often if the individual needs change, the case manager must review the individual's service plan, progress toward goals, and any changes in needs that require changes to the service plan.

The individual's case manager is responsible for monitoring the implementation of the plan. The DBMD provider agency is responsible for ensuring implementation of the DBMD services outlined in the service plan. The individual or legally authorized representative electing to utilize the consumer directed services option is responsible for ensuring implementation of self-directed services.

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

During the service planning process, the case manager ensures consideration of information from the individual, legally authorized representative or both, other service planning team members, and from assessments to determine any risks that might exist to health and welfare as a result of living in the community. Strategies including program services and supports and non-waiver services and supports, formal and informal, are developed to mitigate these risks, and are incorporated into the plan. When an individual requests a transfer to another provider or service delivery option, the case manager assists the individual to transfer from one provider agency or service delivery option to another. All DBMD providers are required to have back-up plans for services that the service planning team determines are essential services.

In the consumer directed services option, the service planning team identifies services critical to the health and welfare of the individual for whom a back-up plan must be developed, documented in the service plan, and approved by the service planning team. Back-up plans may include paid or unpaid service providers, third party resources, and other community resources.

The home and community support services agency has a responsibility under its licensure rules to ensure effective coordination of care with all service providers involved in the care of the individual. It is the home and community support services agency's responsibility to assess the status of an individual.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

When DADS notifies an individual or legally authorized representative that he or she can begin the process of eligibility determination in order to enroll in DBMD services, the individual or legally authorized representative is sent a complete list of DBMD providers in the geographic area in which the individual resides and is encouraged to contact providers to determine which provider best meets the individual's needs. An individual enrolled in DBMD or the legally authorized representative has the option of choosing from the available qualified providers, or having a qualified direct service provider of his or her choice become employed by the DBMD provider, either directly or by contract, if the direct service provider agrees to the rate of compensation available through the waiver as payment in full. The individual or legally authorized representative is informed of this option annually or at his or her request and is provided with a list of qualified providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

HHSC, the State Medicaid Agency, delineates through executive directive the roles and responsibilities of DADS, the operating agency, and HHSC. The executive directive outlines HHSC monitoring and oversight functions. HHSC has delegated the day-to-day approval of service plans to DADS. DADS approves all service plans. DADS also performs at least biennial reviews of each DBMD provider agency which includes reviews of a provider's compliance with the approved service planning requirements. DADS quarterly and annually aggregates data and reports to HHSC. HHSC discusses with DADS any significant findings and if necessary develops a corrective action plan that DADS implements with HHSC oversight.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☑ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

Specify:

The DBMD provider agency and, if appropriate, the financial management services agency.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

When DADS sends notification to an individual to apply for DBMD services, the individual or legally authorized representative is sent a complete list of DBMD providers in the geographic area in which the individual resides and is asked to choose a provider in their geographic area and return their choice sheet to DADS. DADS notifies the chosen provider and the provider agency then contacts the individual to begin the enrollment process.

The case manager is responsible for monitoring the implementation of the service plan and the individual's health and welfare. If the DBMD provider observes a change in the individual's needs, health, or welfare at any time during the service plan year, the DBMD representative is responsible for contacting the case manager, who then convenes a service planning meeting to determine how to address the needs through both DBMD services and non-waiver resources. At a minimum, the case manager meets face-to-face with the individual at least quarterly to review the service plan, the individual's progress towards goals, and any service need changes. If there is an indication of a change in needs, a revision to the service plan is made with the assistance of the individual, legally authorized representative, or both and the service planning team. At least annually, the case manager convenes the service planning team to plan waiver and non-waiver services for the upcoming year.

The DBMD provider agency is responsible for implementing the service plan and back-up plans to protect the individual's health and welfare. The DBMD provider agency provides agency specific emergency contact numbers to the individual and legally authorized representative. The DBMD provider agency is responsible for ensuring necessary services are available to protect the health and welfare of the individual.

At least biennially, during monitoring reviews, DADS ensures that the service plan developed and approved by the service planning team was completed according to instructions, signed by the service planning team, approved by DADS, and that services are being implemented according to the service plan. DADS verifies that an individual or legally authorized representative is provided with agency-specific emergency contact numbers for after-hours

services. DADS ensures the case manager is monitoring service provision in accordance with program rules. DADS also ensures that quarterly reviews are documented by the provider, indicating that the services meet the individual's needs.

Additionally, DADS monitors DBMD provider agencies to ensure compliance with requirements that the provider safeguards the rights of the individual and legally authorized representative to exercise free choice of providers and to transfer to a new provider at any time. If DADS contract monitoring staff determines that an individual requested to transfer to another provider, DADS determines if the transfer occurred, and if it did not, why it did not occur.

The DBMD provider agency is responsible for ensuring that the individual's rights are protected, service plan monitoring occurs as stated in the individual's service plan, required documentation is completed, and follow-up action on contract monitoring findings is taken. As required, DBMD providers are responsible for submitting plans of correction based on any problems identified during monitoring reviews. DADS reviews the submitted plans of correction to determine if the plans are sufficient.

Quarterly and annually, DADS aggregates contract monitoring data and reports it to HHSC. HHSC discusses with DADS any significant findings and if necessary DADS develops a corrective action plan that DADS implements with HHSC oversight.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

The service planning team works with the case manager to ensure that the best interests and needs of the individual are the primary considerations in the service plan development process. The service planning team process ensures that there is no conflict of interest when a case manager who monitors and assists in development of the service plan is employed by the provider agency responsible for providing other direct services. All of the service planning team members contribute to development of the service plan based on the individual's interests, needs, strengths, weaknesses, likes and dislikes. The team assists in determining the types and units of services necessary for the service plan. At least biennially, DADS staff perform monitoring reviews of each DBMD provider agency to determine that the DBMD provider agency follows service planning requirements, including that the individual's needs are being met, service plans change as needs change, and the best interests of the individual is served.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.a.1 Number and percent of individuals with service plans that address individuals' assessed needs and personal goals, either by the provision of waiver services or through other means. N: Number of individuals with service plans that address individuals' assessed needs and personal goals D: Total number of enrolled individuals

Data Source (Select one):
Other
If 'Other' is selected, specify:
DBMD Database; DADS Quality Assurance and Improvement Datamart

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.a.2 Number and percent of individuals' services plans that reflect the service plan addressed health and safety risk factors. N: Number of individuals who have service plans that address health and safety risk factors D: Total number of enrolled individuals

Data Source (Select one):
Other
If 'Other' is selected, specify:
DBMD Database, DADS Quality Assurance and Improvement Datamart

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.b.1 Number and percent of service plans developed in accordance with policies and procedures. N: Number of individuals with service plans developed in accordance with policies and procedures D: Total number of enrolled individuals

Data Source (Select one):
Other
If 'Other' is selected, specify:
DBMD Database; DADS Quality Assurance and Improvement Datamart

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.c.1 Number and percent of individuals' service plans that are reassessed and renewed annually prior to service plan expiration date. N: Number of individuals' service plans that were reassessed and renewed prior to service plan expiration date D: Total number of enrolled individuals

Data Source (Select one):
Other
If 'Other' is selected, specify:
DBMD Database; DADS Quality Assurance and Improvement Datamart

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.c.2 Number and percent of service plans that are revised in response to changes in the individual's needs. N: Number of service plans that were revised in respones to changes in the individual's needs D: Number of service plans reviewed indicating a change in the individual's needs

Data Source (Select one):
Other
If 'Other' is selected, specify:
DBMD Contracts Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Individual cases are

		selected for review based on a five percent sample with a minimum of two individual cases reviewed.
	☑ **Other** Specify: Bienially	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.d.1 #/% of individuals' records that reflect services (other than physical, occupational, or speech and language therapies) are delivered in accordance with the service plan, including type, scope, amount, duration, and frequency. N: Number of individuals' case records that reflect that relevant services are delivered in accordance with their service plan D: Number of individuals reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
DBMD Contracts Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Individual cases are selected for review based on a five percent sample with a minimum of two individual cases reviewed.
	☑ **Other** Specify: Biennially	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other**	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.e.1 Number and percent of individuals who are afforded choice at enrollment between waiver services and institutional care. N: Number of individuals who are afforded choice at enrollment between waiver services and institutional care D: Total number of newly enrolled individuals

Data Source (Select one):
Other
If 'Other' is selected, specify:
DBMD Database; DADS Quality Assurance and Improvement Datamart

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified**

		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.e.2 Number and percent of individuals who are afforded choice between waiver providers. N: Number of individuals who are afforded choice between waiver providers D: Total number of enrolled individuals

Data Source (Select one):
Other
If 'Other' is selected, specify:
DBMD Database; DADS Quality Assurance and Improvement Datamart

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.e.3 Number and percent of individuals who are afforded choice between and among waiver services. N: Number of individuals who are given a choice between and among waiver services D: Total number of enrolled individuals

Data Source (Select one):
Other
If 'Other' is selected, specify:
DBMD Database; DADS Quality Assurance and Improvement Datamart

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

D.e.4 Number and percent of individuals' case records that reflect individuals are afforded choice between service delivery methods. N: Number of individuals' case records that reflect individuals are afforded choice between service delivery methods D: Number of individuals' case records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
DBMD Contracts Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Individual cases are selected for review based on a five percent sample with a minimum of two individual cases reviewed.
	☑ **Other** Specify: Bienially	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
One hundred percent of authorized service plans are reviewed by DADS through desk reviews. If an incomplete or incorrectly completed service plan is submitted to DADS, the plan is returned to the provider for correction. When these plans are returned to providers, a description of the error and required correction is included. The provider must then resubmit the corrected plan, which is reviewed again by DADS staff. The feedback sent to the provider with the remanded service plan is captured in the Deaf Blind with Multiple Disabilities database.

DADS staff use the Service Authorization System to authorize waiver services and to collect, process, and report individual service authorization data. The Service Authorization System can generate a wide variety of reports. The Service Authorization System maintains the following information:

- Participant Information about individuals who are enrolled and their service authorizations. The system records contain information such as contact information, enrollment data, authorized service period, allotted amounts of each service, and service plan changes and reassessments.

- Provider Information about service providers. The system records contain information such as types of services and number of units each provider is authorized to deliver for each participant.

- Billing and Payment Information related to specific rate information for each type of service. DBMD case managers, with the service planning teams, recommend specific services for participants. The provider may bill for services only after the Department of Aging and Disability Services has authorized those services in the system.

- Medicaid Eligibility Service Authorization Verification reports that providers can access information about individuals for whom they are authorized to deliver services. This information includes Medicaid eligibility, level of care, co-payment, level of service, and service authorization.

One hundred percent of Deaf Blind with Multiple Disabilities providers are reviewed by DADS Community Services Contracts staff at least every two years. This monitoring includes a review of the service plans for individuals in the sample.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Technical assistance is shared with providers throughout the DADS Community Services Contracts review. If, during a contract monitoring review, a provider is discovered to not have submitted a service plan within the required timeframe or if a service plan is missing signatures, the provider agency is required to submit a corrective action plan to the Department of Aging and Disability Services. The corrective action plan must contain the following elements:

- The title of the person responsible for the action;
- A description of the action to be accomplished;
- The date the action will be implemented; and
- The action to ensure compliance.

If a corrective action plan is requested from the provider, the provider is informed that they may contact DADS staff with any questions or requests for clarification of what constitutes an acceptable corrective action plan. Upon submittal, DADS reviews the corrective action plan and either approves or, if the submitted plan does not include all of the required elements, requests revisions and resubmission. Providers are informed that their failure to ensure DADS receives an acceptable corrective action plan by the date specified by DADS may result in DADS taking adverse action against the provider, up to and including termination of the provider agreement/contract. DADS monitors the corrective action plan until the provider is in compliance.

DADS Community Services Contracts staff submits provider agreement/contract action recommendations to the Sanction Action Review Committee when a complaint investigation against a provider substantiates a reported allegation or DADS Community Services Contracts staff recommend the provider receive a contract action/sanction greater than only a corrective action plan. Sanction Action Review Committee members review the monitoring review results and, if applicable, review complaint investigation findings to ensure the circumstances support the recommended provider agreement/contract action. The Sanction Action Review Committee makes a decision on the appropriate action to take, including submission of a corrective action plan; placing a hold on individual referrals for new individuals; placing a hold on provider payments; financial recoupment; involuntary contract termination; and debarment.

Results of each contract monitoring review are documented and recorded in an Access database maintained in the state office.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. **Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Participation in the consumer directed services option provides the individual, or the legally authorized representative, the opportunity to be the employer of persons providing waiver services chosen for self-direction. Individuals residing in their own private residence or the home of a family member may choose to self-direct any of the following services: residential habilitation, intervener services, supported employment, employment assistance, and respite.

The traditional agency option (provider-managed) provides any services not available through the consumer directed services option and any services that the individual or legally authorized representative elects not to self-direct. Under the traditional agency option, individuals choose a contracted provider.

Each individual or legally authorized representative electing to use the consumer directed services option must receive support from a financial management services provider, referred to as a financial management services agency, chosen by the individual or legally authorized representative. An individual or legally authorized representative may also self direct support consultation, which is available only to individuals who choose the consumer directed services option.

When choosing to self-direct services, the individual or the legally authorized representative is the common-law employer of service providers and has decision-making authority over providers of self-directed services. The individual or the legally authorized representative also has budget authority. DADS approves funding for self-directed services based on the authorized service plan. The employer or designated representative, with the assistance of the financial management services agency, budgets approved funds for self-directed services.

The case manager informs the individual, legally authorized representative, or both of the option to self-direct the services indicated above at the time of enrollment in the waiver, at least annually thereafter, and upon request of the individual or legally authorized representative. The individual or legally authorized representative may elect at any time to choose the consumer directed services option, terminate participation in the consumer directed services option, or to change financial management services agencies.

Supports for the individual directing services or the individual's legally authorized representative include:

1. The case manager, who provides information about the consumer directed services option and monitors service delivery. The case management functions are global and apply to self-directed as well as provider-managed waiver services and non-waiver services;
2. A financial management services agency, chosen by the individual or legally authorized representative, to provide financial management services. The financial management services agency must hold a Medicaid provider agreement (contract) with DADS on behalf of HHSC.

Supports may also include:

1. A certified support advisor chosen by the individual or legally authorized representative employer if the individual or legally authorized representative has chosen to receive support consultation, who assists the individual or legally authorized representative employer in learning about and performing employer responsibilities; and
2. A designated representative, if appointed by the individual or legally authorized representative employer, who assists in meeting employer responsibilities to the extent directed by the employer;

To participate in the consumer directed services option, an individual or legally authorized representative must:

1. Select a financial management services agency;
2. Participate in orientation and ongoing training conducted by the financial management services agency;
3. Perform all employer tasks that are required for self-direction or designate a designated representative capable of performing some or all of these tasks on the individual's behalf; and
4. Maintain a service back-up plan for provision of services determined by the service planning team to be critical to the individual's health and welfare.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

A DBMD individual is offered the opportunity to self-direct services when:

1. The individual lives in his or her own home or the home of a family member; and
2. The service plan includes residential habilitation, respite, supported employment, employment assistance, or intervener.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The case manager provides each individual and legally authorized representative a written and oral explanation of the consumer directed services option at the time of enrollment in DBMD, at each annual review of the service plan, and at any time requested by the individual or legally authorized representative.

Each individual or legally authorized representative is provided information sufficient to assure informed decision-making and understanding of the consumer directed services option and of the traditional agency-directed (provider-managed) service delivery option. The information includes the responsibilities and choices individuals can make with the election of the consumer directed services option.

Information provided orally and in writing to the individual and the legally authorized representative by the case manager includes:

1. An overview of the consumer directed services option;
2. Explanation of responsibilities in the consumer directed services option for the individual or individual’s legally authorized representative, case manager, and the financial management services agency;
3. Explanation of benefits and risks of participating in the consumer directed services option;
4. Self-assessment for participation in the consumer directed services option;
5. Explanation of required minimum qualifications of service providers through the consumer directed services option; and

6. Explanation of employee/employer relationships that prohibit employment under the consumer directed services option.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☐ **Waiver services may be directed by a legal representative of the participant.**
- ☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The individual or the legally authorized representative serving as the consumer directed services employer may appoint an adult who is not the legally authorized representative as a designated representative to assist in performance of employer responsibilities to the extent desired by the individual or legally authorized representative. The consumer directed services employer documents the employer responsibilities that the designated representative may perform and those that the designated representative may not perform on the consumer directed services employer's behalf. The consumer directed services employer provides this documentation to the financial management services agency. The financial management services agency monitors performance of employer responsibilities performed by the consumer directed services employer and, when applicable, the designated representative in accordance with the consumer directed services employer documented directions. Neither the designated representative nor the spouse of the designated representative may be employed by, receive compensation from, or be the provider of waiver services for the individual.

To ensure that designated representative functions in the best interests of the individual, safeguards are in place that include restrictions preventing the designated representative from:

- signing or representing himself as the employer,
- providing a program service, or
- being paid to perform employer responsibilities.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Employment Assistance	☑	☑
Supported Employment	☑	☑
Residential Habilitation	☑	☑
Respite	☑	☑
Support Consultation	☑	☑
Intervener	☑	☑

Waiver Service	Employer Authority	Budget Authority

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:
Financial Management Service

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Private entities furnish financial management services. These entities, called financial management services agencies, are procured through an open enrollment process and the State has Medicaid provider agreements with multiple entities to provide financial management services to individuals across the state.

DADS, on behalf of HHSC, executes a Texas Medicaid provider agreement with each financial management services agency. These agreements include additional State contract requirements.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Entities are compensated with a flat monthly fee per individual served.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☑ **Assist participant in verifying support worker citizenship status**
☑ **Collect and process timesheets of support workers**
☑ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [x] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [x] **Other**

Specify:

Runs criminal history checks

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

HHSC has delegated to DADS the responsibility of executing Medicaid provider agreements, including day to day operations of financial management services and monitoring of financial management services agencies. DADS conducts monitoring reviews of each financial management services agency to determine if it is in compliance with the Medicaid provider agreement and with program rules and requirements. These reviews are conducted via desk reviews or at the location where the financial management services agencies are providing financial management services. Texas monitors 100 percent of financial management services agencies at a minimum of every three years. DADS reports the results of the monitoring to HHSC.

DADS assesses a financial management services agency's performance by:

1. Measuring adherence to rules in Title 40 of the Texas Administrative Code, Part 1, Chapter 41;
2. Matching payroll, optional benefits and tax deposits to time sheets;
3. Ensuring that the hours worked and the rate of pay are consistent with individual budgets;
4. Reviewing administrative payments; and
5. Reviewing the provider agreements.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify

the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Information provided orally and in writing to the individual and the legally authorized representative by the case manager includes:

1. An overview of the consumer directed services option;
2. Explanation of responsibilities in the consumer directed services option for the individual or individual's legally authorized representative, case manager, and the financial management services agency;
3. Explanation of benefits and risks of participating in the consumer directed services option;
4. Self-assessment for participation in the consumer directed services option;
5. Explanation of required minimum qualifications of service providers through the consumer directed services option; and
6. Explanation of employee/employer relationships that prohibit employment under the consumer directed services option.

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Orientation and Mobility	☐
Behavioral Support	☐
Nursing	☐
Dental Treatment	☐
Employment Assistance	☐
Supported Employment	☐
Residential Habilitation	☐
Transition Assistance Services	☐
Respite	☐
Day Habilitation	☐
Prescribed Drugs	☐
Minor Home Modifications	☐
Chore Service	☐
Financial Management Services	☑
Case Management	☐
Support Consultation	☑
Physical Therapy Services	☐
Adaptive Aids and Medical Supplies	☐
Speech, Hearing, and Language Therapy Services	☐
Occupational Therapy Services	☐
Intervener	☐
Audiology Services	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
	☐
Assisted Living	☐
Dietary Services	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

An individual or legally authorized representative may voluntarily terminate participation in the consumer directed services option at any time. The case manager assists with revising the service plan for the transition of services previously delivered through the consumer directed services option to be delivered by the program provider chosen by the individual or legally authorized representative. The service planning team assists the individual as necessary to ensure continuity of all waiver services through the traditional agency- directed (provider-managed) service delivery option and maintenance of the individual's health and welfare during the transition from the consumer directed services option.

The financial management services agency closes the employer’s payroll and payable accounts and completes all deposits and filings of required reports with governmental agencies on behalf of the individual. When an individual voluntarily terminates self-direction of services, the case manager will assist the individual to begin services through the agency option with no gap in coverage. The individual must wait 90 days before returning to the consumer directed services option.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. **Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

An individual's service planning team, financial management services agency, or DADS may recommend termination of participation in the consumer directed services option if the individual, legally authorized representative, or designated representative does not implement and successfully complete the following steps and interventions:

1. Address risks to the individual's health or welfare;
2. Successfully direct the delivery of program services through consumer directed services;
3. Meet employer responsibilities as listed in E-2-a(ii), Participant Employer Authority, and E-2-b(i), Participant Decision Making Authority;
4. Successfully implement corrective action plans; or
5. Appoint a designated representative or access other available supports to assist the employer in meeting employer responsibilities.

DADS may require immediate termination of participant direction in circumstances that jeopardize health and safety, when the designated representative is convicted of a crime, or if another regulatory agency recommends termination. (Title 40 of the Texas Administrative Code, Part 1, Chapter 41).

The individual's case manager and service planning team assist the individual to ensure continuity of all waiver services through the traditional agency (provider-managed) service delivery option and maintenance of the individual's health and welfare during the transition from the consumer directed services option. The case manager must assist with revising the service plan for the transition of services previously delivered through the consumer directed services option that will be delivered by the program provider chosen by the individual or legally authorized representative. The financial management services agency closes the employer's payroll and payable accounts and completes all deposits and filing of required reports with governmental agencies on behalf of the individual.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. **Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		4
Year 2		4
Year 3		4
Year 4		4
Year 5		4

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. **Participant - Employer Authority** *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both*:

- [ ] **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

  Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- [x] **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

- [x] **Recruit staff**
- [ ] **Refer staff to agency for hiring (co-employer)**
- [ ] **Select staff from worker registry**
- [x] **Hire staff common law employer**
- [x] **Verify staff qualifications**
- [x] **Obtain criminal history and/or background investigation of staff**

  Specify how the costs of such investigations are compensated:

  Funds available in the individual's consumer directed services budget are used for this purpose.

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

  Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The service plan is developed in the same manner for the individual who elects the consumer directed services option as it is for the individual who elects to have services delivered through the traditional (provider-managed) service delivery option. The service plan must be approved by DADS. The consumer directed services budget is the estimated cost of the self-directed services in the approved service plan and the adopted consumer directed services reimbursement rates. The consumer directed services budget is developed by the individual or legally authorized representative with assistance from the financial management services agency.

The consumer directed services budget is allocated to each self-directed service based on the approved service plan. The budget for each service, and any revisions, must be approved by the financial management services agency prior to implementation. The financial management services agency must ensure that projected expenditures are within the authorized budget for each service, are allowable and reasonable, and are projected over the effective period of the plan to ensure that sufficient funds will be available to the end date of the service plan. With approval of the financial management services agency, the individual or legally authorized representative may make revisions to a specific service budget that do not change the amount of funds available for the service based on the approved service plan.

Employer-related costs are paid for using the consumer directed services budget and include costs for equipment, supplies or activities that will provide direct benefit to the individuals who self-direct services to support specific outcomes related to being an employer including: recruiting expenses, fax machine for sending employee time sheets to the financial management services agency, criminal conviction history checks from the Texas Department of Public Safety, acquiring other background checks of a potential service provider, purchased employee job-specific training, cardio-pulmonary resuscitation training, first-aid training, and Hepatitis B vaccination if elected by an employee. An individual may use up to a maximum of $600 of the consumer-directed budget for employer-related support activities.

Support consultation has a specific reimbursement rate and is a component of the individual's service budget. In conjunction with the service planning team, the individual or legally authorized representative determines the level of support consultation necessary for inclusion in the individual's service plan.

Revisions to the budget for a particular service or a request to shift funds from one service to another is a service plan change and must be justified by the service planning team and authorized by DADS. With assistance of the financial management services agency, the individual or legally authorized representative revises the consumer directed services budget to reflect the revision in the service plan.

Information concerning budget methodology for the consumer directed services budget is available to the public in Title 40 of the Texas Administrative Code, Part 1, Chapter 41, Subchapter E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The individual or the legally authorized representative participates as a member of the service planning team that develops the individual's person-directed plan, upon which the service plan is based. The individual or legally authorized representative is apprised of the budget as it is developed. The individual develops the consumer directed services budget based on the finalized service plan and authorized budget. The financial management services agency and the case manager inform the individual/employer of the amount authorized for the particular service before the budget is developed.

During the service planning process, the case manager informs the individual or legally authorized representative of procedures to request a revision to the service plan. The individual/employer may request an adjustment to the budget at any time, subject to cost ceilings. An individual whose request of an adjustment to his or her participant-directed budget is denied is entitled to a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A. The case manager sends written notification to the individual or legally authorized representative, indicating the reason for the denial, the individual's right to a fair hearing, and the process the individual must follow to request a fair hearing. The specific procedures for a fair hearing are provided in Appendix F, Individual Rights.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

An individual's consumer directed services budget is calculated and monitored based on projected utilization and frequency of the services as determined by the service planning team. The financial management services agency is required to monitor payroll every pay period (two weeks) and expenditures (as processed for payment) and report over- and under-utilization to the individual-employer and the case manager. When an over- or under-utilization is not corrected by the individual-employer or legally authorized representative, the financial management services agency notifies the case manager and the individual-employer. The case manager and the individual-employer identify the cause of continuing deviation from projected utilization and develop a plan to correct the deviation or revise the service plan.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

At the time of enrollment, at least annually, and upon request, the case manager shares the individual's rights and responsibilities with the individual or legally authorized representative and obtains the individual's or legally authorized representative's signature acknowledging receipt of the information. These rights include the right to participate in decisions and to be informed of the reasons for decisions regarding plans for enrollment, transfer, reduction or termination of a service, or denial of program services.

If services are reduced, denied or terminated, an individual is entitled to a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A. DADS sends a letter to the provider that outlines the fair hearing procedure. The provider is responsible for providing a copy of the letter to the individual or legally authorized representative. This letter informs the individual of the opportunity to request a fair hearing via the Fair Hearing Request form. The notification explains the person's right of appeal, and the right to have others represent the individual, including legal counsel. The provider may provide information to individuals concerning available legal services in the community.

An opportunity for a fair hearing under 42 Code of Federal Regulations, Part 431, Subpart E, will be offered to individuals who are not given the choice of home or community-based services as an alternative to institutional care or who are denied the service(s) of their choice. DADS and the provider retain copies of the notice of adverse action taken by the State and the notice to the individual of the opportunity to request a fair hearing. The notice informs an individual or legally authorized representative whether or not the individual is eligible to receive or continue to receive services while the individual's appeal is under consideration and the actions that the individual must take in order for current services to continue. If an individual or legally authorized representative elects to request a fair hearing, DADS retains a copy of the individual's written request for a hearing in the individual's record. Individuals or legally authorized representatives have 90 days from the date of the notice of the action to request a fair hearing. In cases where services are being reduced or terminated, the notice includes the date by which the individual or legally authorized representative must request the hearing in order to maintain the individual's current level of services, pending the hearing decision. If an individual or legally authorized representative requests a fair hearing within the 90-day period but after the date of the proposed reduction or termination, services are not continued pending the hearing decision. If an individual requests a fair hearing, DADS sends a Petition for Fair Hearing,

within five calendar days of receipt of the request, to the HHSC hearing officer.

The hearing officer sends a Notice of Fair Hearing to the appellant and to DADS to acknowledge the request for a hearing and to set a time, date, and place for the hearing. DADS sends a Petition for Fair Hearing Addendum and copies of all relevant documentation to all known parties and required witnesses at least 14 calendar days prior to the scheduled hearing. After the hearing, the hearing officer files the decision in the appeal file. DADS implements the decision of the hearing officer within 10 calendar days of the date of the decision and documents to the HHSC hearing office that the decision has been implemented.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

HHSC and DADS operate the grievance and complaint system.

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

To facilitate an efficient consumer response system, DADS has identified the Office of Consumer Rights and Services as its centralized source for the receipt of complaints. DADS Office of Consumer Rights and Services staff receives complaints from an individual seeking enrollment or from an individual already enrolled in the waiver, or his or her legally authorized representative, family, and representatives. The DADS Office of Consumer Rights and Services acknowledges and responds to all complaints in a timely, professional manner and ensures that they are referred to the proper authorities.

The individual may file complaints against providers or against DADS staff. A complaint may include issues such as inappropriate behavior, violations of DADS policies or rules, violations of DADS work rules, violations of confidentiality, conflict of interest, inappropriate influence, or criminal activity. An individual may also report

concerns and questions regarding the facilities or providers regulated by DADS, and DADS services, programs or staff.

DADS staff advises complainants that the formal filing of a complaint is not a substitute for, and is not required in order for the individual to request a fair hearing if enrollment or services are denied, terminated, reduced, or suspended. At the time of an individual's enrollment in the waiver, the case manager also advises the individual that the individual filing a complaint is not a pre-requisite or substitute for requesting a fair hearing.

Grievances or complaints can be submitted by telephone by calling a toll-free line, by e-mail, or by written correspondence. DADS staff answers the toll-free line from 7 a.m. to 7 p.m., Monday through Friday. Voice mail is available 24 hours a day and is monitored by DADS staff from 8 a.m. to 5 p.m. on Saturday, Sunday, and holidays. Voice mail is also monitored during business hours on weekdays.

Complaints and grievances left on voice mail are monitored by Complaint Intake program specialists and returned the day received or within 24 hours after receipt. Complaints and grievances may be anonymous. The identity of complainants and individuals is protected as allowed by law. An individual has the right to make a complaint, voice a grievance, or recommend changes in policy or service, without restraint, interference, coercion, discrimination, or reprisal.

Grievances are concerns filed against home and community support services agency employees that are related to inappropriate or unprofessional conduct. Some examples of grievances include inappropriate attire and lack of cooperation with administrative tasks such as form completion. Home and community support services agencies are responsible for addressing grievances and ensuring appropriate action is taken. DADS Regulatory Services reviews grievances and the actions taken by the home and community support services agencies during routine surveys.

DADS Consumer Rights and Services staff triage and refer complaints regarding a DADS licensed agency or facility, including assisted living facilities contracted to provide waiver services, to DADS Regulatory Services and DADS Community Services Contracts. DADS must acknowledge the complaint within 14 days after the date DADS receives it and respond within two to 120 days after that date, based on the type of complaint.

If DADS Regulatory Services conducted the initial investigation, DADS Community Services Contracts staff must initiate the complaint investigation within 45 workdays of the date the staff receives either the Report of Investigation or Statement of Licensing Violations and Plan of Correction form from DADS Regulatory Services. If DADS Regulatory Services does not initiate an investigation, DADS Community Services Contracts staff must initiate the complaint investigation within 45 workdays from the date DADS Consumer Rights and Services posted the intake to the designated Outlook mailbox.

The complaint investigation is initiated when DADS Community Services Contracts staff makes the first contact with the complainant or the provider. Contact may be made face-to-face, by telephone or via fax. DADS Community Services Contracts staff must complete the on-site or desk review investigation within 15 workdays from the date the investigation was initiated.

DADS Community Services Contracts staff maintains a complaint log for the purpose of collecting, reviewing and reporting complaint information. On a monthly basis, DADS Community Services Contracts staff compile the Complaint Activity Report and the Complaint Resolution Activity Report and post the reports electronically to a designated folder on the Health and Human Services Contract Administration Tracking System Reports shared drive. DADS Community Services Contracts staff is responsible for reporting contract management activities, including investigations, to Contract Oversight and Support for entry into the Health and Human Services Contract Administration Tracking System.

Except for complaints regarding DADS licensed assisted living and nursing facilities, which DADS investigates, complaints involving allegations of the abuse, neglect, or exploitation of an individual receiving waiver services are reported immediately to the Texas Department of Family and Protective Services, the agency with statutory responsibility for investigation of such allegations. Home and community support services agencies are required to report allegations of abuse, neglect or exploitation to the Department of Family and Protective Services and DADS Regulatory Services. DADS Regulatory Services investigates these allegations to determine whether the licensed home and community support services agency responded appropriately to the allegations.

When Consumer Rights and Services staff determines DADS has no jurisdiction to investigate, complaints are

referred to other agencies, boards or entities as required.

The HHSC Office of the Ombudsman assists the public when the DADS normal complaint process cannot, or does not, satisfactorily resolve an issue. The Office of the Ombudsman may be a complainant or investigator for a complaint. The Office of the Ombudsman includes the following services:
* Conducting independent reviews of complaints concerning agency policies or practices;
* Ensuring that policies and practices are consistent with the goals of HHSC;
* Ensuring that individuals are treated fairly, respectfully, and with dignity; and
* Making referrals to other agencies as appropriate

The process to assist with complaints and issues is as follows:
* A member of the public, an individual, or a provider makes first contact with HHSC or with DADS to request assistance with an issue or complaint;
* If not able to resolve the issue or complaint, the Office of the Ombudsman may be contacted;
* The Office of the Ombudsman will provide an impartial review of actions taken by the program or department;
* The Office of the Ombudsman will seek a resolution.

This policy only applies to assisted living facilities and nursing facilities.

Often it is necessary for the Office of the Ombudsman to refer an issue to the appropriate department. If so, the Office of the Ombudsman will follow up with the complainant to determine if a resolution has been achieved, or to refer the complainant to other available known resources.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DBMD providers must hold a home and community support services agency license, and if providing assisted living services to four to six individuals, an assisted living facility license. DADS licensing and contracting rules contain requirements related to reporting incidents and complaints. DADS monitors DBMD provider compliance with these requirements.

DADS licenses home and community support services agencies in accordance Title 40 of the Texas Administrative Code, Part 1, Chapter 97, and assisted living facility providers in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 92. DBMD providers licensed as home and community support services agencies are required to report any instance of abuse, neglect, or exploitation of an individual to the Department of Family and Protective Services and to DADS immediately upon suspicion of such activities. The Department of Family and Protective Services investigates the allegation and makes a determination as to whether abuse, neglect or exploitation occurred. In some instances, the Department of Family and Protective Services may offer services, if

appropriate.

DBMD providers licensed as assisted living facility providers are required to report allegations of abuse, neglect, and exploitation directly to DADS immediately upon suspicion of such activities. Assisted living facility providers make reports of suspected abuse, neglect, or exploitation by telephone to either the State abuse hotline or the licensing complaint hotline. Individuals may report suspected instances of abuse, neglect, or exploitation using either telephone number 24 hours a day. Providers must report critical incidents pursuant to the terms of their contract with DADS. Should the provider become aware of a critical incident, it will report that incident to DADS.

Intermediate care facilities providing out-of-home respite are also required to immediately report abuse, neglect, and exploitation to DADS under DADS licensure rules. Those reports are investigated by DADS Regulatory staff.

A DBMD provider must report the death of an individual to DADS within 24 hours.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

At the time an individual is enrolled in DBMD they are informed of their rights and responsibilities, which include their right to be free from abuse, neglect, and exploitation. The toll free numbers for DADS and the Department of Family and Protective Services must be provided. Facilities must post the information in a conspicuous place. Evidence supporting compliance with these requirements is reviewed during DADS' on-site licensure surveys and program and fiscal monitoring reviews of the program provider.

In addition to information provided to all individuals enrolled in the waiver, a financial management services agency provides individuals electing the consumer directed services option with training and written information related to reporting allegations of abuse, neglect, or exploitation.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

DADS and the Department of Family and Protective Services are responsible for receiving and reviewing critical event/incident reports. All complaints of abuse, neglect, or exploitation against home and community support services agency licensed providers are referred to the Department of Family and Protective Services. DADS investigates complaints of abuse, neglect, or exploitation in assisted living homes and may take a range of enforcement actions including administrative penalties and licensure revocation. Licensure rules for assisted living providers require all assisted living facility staff to complete an orientation that includes training regarding the reporting of abuse and neglect. DADS Educational Services staff provides on-line and in-person training opportunities for assisted living providers including training regarding common licensure violations. DADS Regulatory Services staff ensures that licensed providers have policies that protect the health and welfare of individuals when an allegation of abuse, neglect, or exploitation is received involving an employee, contractor, or volunteer.

DADS investigations:
The DADS Consumer Rights and Services Complaint Intake unit receives, records, triage's and tracks alleged abuse, neglect, or exploitation related to assisted living providers in the Compliance, Assessment, Regulatory Enforcement System database. Abuse, neglect or exploitation reports are also recorded in the home and community support services agency Information Tracking database, which includes tracking of reports that are referred to the Department of Family and Protective Services for abuse, neglect, or exploitation investigation. The Consumer Rights and Services Complaint Intake unit is responsible for entering all data into the home and community support services agency Information Tracking database.

After receipt and triage, Consumer Rights and Services Complaint Intake unit staff refer reports of abuse, neglect, or exploitation alleged to have occurred in an assisted living facility to DADS Regulatory Services surveyors for investigation. Investigations that include abuse, neglect, or exploitation allegations must be initiated consistent with the following priority categories:

On-or-before 24 hours - An immediate response by Regulatory Services is warranted because a provider allegedly created or allowed a present and ongoing situation in which the provider's noncompliance with one or more requirements of licensure has failed to protect residents from abuse, neglect, or mistreatment or has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

On-or-before 14 calendar days - The present or ongoing threat of continued abuse, neglect, or mistreatment has been removed, and residents are no longer in imminent danger; however, the provider's alleged noncompliance with one or more requirements of licensure may have or has a high potential to cause harm that impacts a resident's mental, physical, or psychosocial status and is of such consequence that a rapid response by DADS Regulatory Services is indicated. There is evidence or suspicion that system(s) failure contributed to or brought on the threat.

Professional Review - A provider who has cause to believe that the physical or mental health or welfare of a resident has been, or may be, adversely affected by mistreatment, neglect, or abuse must self-report the incident to DADS immediately on learning of the alleged conduct or conditions. This includes injuries of unknown source and exploitation/misappropriation of resident property.

DADS Consumer Rights and Services Complaint Intake unit staff assigns a Professional Review priority when a provider self-reports an incident of abuse, neglect, or exploitation, and the provider's oral report indicates that the provider's immediate corrective action is reasonably likely to ensure that abuse, neglect, mistreatment, or injury to a resident(s) will not occur again, or at least not while the provider conducts their investigation and the provider's written investigation report is received and reviewed by a Complaint Intake program specialist.

A review of the Provider Investigation Report by a DADS Consumer Rights and Services Complaint Intake unit nurse specialist will include an assessment of the provider's description of the incident, the provider's summary and analysis of the investigation procedures, the provider's conclusion as to whether the allegation is supported by the provider's professional judgment, and recommendation(s) or corrective action(s) taken by the provider as a result of the investigation findings. Based on review of the facility investigation report, if further investigation is warranted to assess whether the provider's abuse prohibition polices ensure compliance with regulatory requirements, the Complaint Intake staff will send the intake for on-site investigation.

The Department of Family and Protective Services Investigations:
Adult Protective Services, a division of the Department of Family and Protective Services, is responsible for investigating allegations of abuse, neglect, or exploitation of adults who are elderly and those with disabilities, including cases in which a contracted provider is alleged to have abused, neglected, or exploited an individual. Adult Protective Services records and tracks reports of abuse, neglect, or exploitation.

The Department of Family and Protective Services assigns one of four priority levels to complaints at the time of the complaint intake. The Department of Family and Protective Services complaint investigators must contact the alleged victim by phone within 24 hours of intake. The investigator may change the priority level as a result of the phone contact. The Department of Family and Protective Services must make the initial face-to-face contact with the alleged victim based on the priority level. Priority one cases require response within 24 hours; priority two cases require response within three calendar days; priority three cases require response within 7 calendar days; and priority four cases require response within 14 calendar days.

The Department of Family and Protective Services notifies DADS of substantiated abuse, neglect, or exploitation complaints providing due process to the perpetrator. DADS may coordinate with Adult Protective Services to determine the resolution of the abuse, neglect, or exploitation allegation. Contracted providers are required to protect individuals from abuse, neglect, or exploitation under consumer rights rules and report potential incidences of abuse, neglect, or exploitation. The methods of investigations and the time frames for completing them vary by the type of event or incident and investigating party. Other specific information regarding processes and time frames is available in the licensing requirements, the Department of Family and Protective Services procedures, or contract rules.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Department of Family and Protective Services is responsible for handling all reports of abuse, neglect, and exploitation of adults receiving services in the community, except for those occurring in an assisted living facility. Upon completion of an investigation in which abuse, neglect, or exploitation is validated against an employee of a

home and community support services agency and after due process is complete, the Department of Family and Protective Services investigator releases the investigation findings to DADS. DADS reviews all investigation reports provided by the Department of Family and Protective Services. Based on the content of the report, DADS may conduct an on-site survey of the provider or require the provider to submit evidence of follow-up action on the incident. DADS Regulatory Services staff enter the investigative findings into a database and DADS follows up on those findings. DADS also records deaths in a database. Reports of critical incidents are compiled on a monthly basis for each program provider. In preparation for biennial and some intermittent reviews of providers, DADS staff compiles data related to all critical incidents reported by or involving the program provider. DADS may use this information in selecting the sample of individuals whose records will be reviewed and who may be interviewed to ensure appropriate follow-up was conducted by the program provider.

DADS is responsible for investigating all other critical events and incidents, including allegations of abuse, neglect, and exploitation occurring in an assisted living facility. DADS records the outcomes of abuse, neglect, and exploitation investigations in the Compliance Assessment Regulation Enforcement Systems database. All critical incidents reported to DADS as required by licensure regulations are investigated. Investigation of some self-reported incidents may be completed without an on-site investigation. If further investigation is warranted to ensure compliance with federal, state, or local laws, an on-site investigation is scheduled.

Oversight activities occur on an ongoing basis. Information regarding validated instances of abuse, neglect, and exploitation is monitored, tracked and trended for purposes of training DADS staff and to prevent recurrence.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Licensing requirements for assisted living facilities prohibit the use of restraints unless it is a behavioral emergency and ordered by a physician. A provider may use physical or chemical restraints (seclusion is not permitted) only if the use is authorized in writing by a physician or if the use is necessary in an emergency to protect the individual or others from injury. If restraints are used in a behavioral emergency, they must be administered by qualified medical personnel. A physician's written authorization for the use of restraints must specify the circumstances under which the restraints may be used and the duration for which the restraints may be used. Any use of restraints must be documented by the provider. The facility must develop policies and procedures based on the facility's needs and population to determine if restraints will be used in the facility.

A restraint may not be administered under any circumstance if it obstructs the individual's airway, including a procedure that places anything in, on, or over the individual's mouth or nose; impairs the individual's breathing by putting pressure on the individual’s torso; interferes with the individuals ability to communicate; or places the individual in a prone or supine position.

If a facility uses a restraint hold, they must make an appointment with the individual's physician, with the individual's consent, and document that the appointment was made. If the individual refuses to see their physician, the facility must document the refusal. The facility must notify the individual's legally authorized representative, or the person actively involved in the individual's care, unless the release of this information will violate other laws.

Attendants must have training that includes the topic of behavior management practices within the first 16 hours of employment following orientation. Behavior management practices include the prevention of aggressive behavior and de-escalation techniques to decrease the frequency of the use of restraints. Attendants must also complete one hour of training annually in behavior management practices, such as prevention of aggressive behavior and de-escalation techniques, fall prevention, and alternatives to restraints.

Facilities that employ licensed nurses, certified nurse aides, or certified medication aides must provide annual in-service training, appropriate to their job responsibilities.

Intermediate care facilities that provide out-of-home respite must report the use of restraints to DADS. Intermediate care facilities must evaluate use of restraints at least annually. The evaluation must, at a minimum, compare aggregate data provided by DADS. Based on an intermediate care facility's evaluation, the program provider must develop and implement a plan to reduce the use of restraints.

DADS does not allow restraints in any other setting where services may be delivered. DADS monitors improper use of restraints through on-site surveys and complaint investigations. Seclusion is prohibited.

The State does not prescribe specific alternative methods to be used to avoid restraints. Restraints are prohibited for the purpose of behavioral management, staff convenience, or discipline.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Complaints concerning unnecessary or unapproved use of restraint can be made to DADS or the Department of Family and Protective Services. The DBMD provider must assure that an individual or legally authorized representative is informed orally and in writing of the processes for filing complaints about the provision of DBMD services including:

• The toll-free telephone number of DADS Consumer Rights and Services to file a complaint; and
• The toll-free telephone number of the Department of Family and Protective Services to file a complaint of abuse, neglect, or exploitation.

DADS monitors the improper use of restraints through on-site surveys and complaint investigations.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The primary function for the use of restrictive interventions is for safety and positioning in specific circumstances once the use of non-aversive methods have failed and been clearly documented. Prior to authorizing the use of restrictive interventions, the following must occur:

• The individual's needs must be assessed.
• There must be a physician's order for the use of restrictive interventions.
• The home and community support services agency registered nurse with, input from the individual, the individual's legally authorized representative, the individual's service planning team, and other professional personnel, must develop a written plan.
• The restrictive intervention must be clearly documented on the service plan, including under what circumstances and what type of restrictive intervention is to be used.
• The service planning team must approve the service plan.
• Written consent of the individual or legally authorized representative must be documented in the case record.
• Verbal and written notification to the individual or legally authorized representative must be provided describing the right to discontinue use of the restrictive intervention at any time.
• Allowance for a revised plan must be made when the restrictive intervention is not working.
• The effects of the techniques in relation to the individual's health and welfare must be considered.
• At least annually, the service planning team must review the need for use of the restrictive intervention to determine the effectiveness of the program and the need to continue the restrictive intervention.
• Each person who is to apply the restrictive intervention must be trained in the proper use at least annually and as the needs of the individual change. The training must be documented in the case record.

DADS monitors potential improper and unauthorized use of restrictive interventions through on-site surveys and complaint investigations.

Complaints concerning the use of restrictive interventions can be made to DADS or the Department of Family and Protective Services. The DBMD provider must assure that an individual or legally authorized representative is informed orally and in writing of the processes for filing complaints about the provision of DBMD services including:

• The toll-free telephone number of DADS Consumer Rights and Services to file a complaint; and
• The toll-free telephone number of the Department of Family and Protective Services to file a complaint of abuse, neglect, or exploitation.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

DADS monitors improper and unauthorized use of restrictive interventions through on-site surveys and complaint investigations. Complaints concerning the use of restraint can be made to DADS or the Department of Family and Protective Services. The DBMD provider must assure that an individual or legally authorized representative is informed orally and in writing of the processes for filing complaints about the provision of DBMD services including:

• The toll-free telephone number of DADS Consumer Rights and Services to file a complaint; and
• The toll-free telephone number of the Department of Family and Protective Services to file a complaint of abuse, neglect, or exploitation.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. **Use of Seclusion.** *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The State prohibits the use of seclusion

DBMD Providers must be licensed home and community support services agencies. DADS Regulatory Services surveys home and community support services agencies during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. DADS surveys assisted living facilities biennially. DADS may survey or monitor facilities or home and community support services agencies more frequently if appropriate.

Complaints concerning unapproved use of seclusion can be made to DADS, or the Department of Family and Protective Services. The DBMD provider must assure that an individual or legally authorized representative is informed orally and in writing of the processes for filing complaints about the provision of DBMD services including:
• The toll-free telephone number of DADS Consumer Rights and Services to file a complaint; and
• The toll-free telephone number of the Department of Family and Protective Services to file a complaint of abuse, neglect, or exploitation.
DADS monitors the unapproved use of seclusion through on-site surveys and complaint investigations.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

DBMD providers holding a home and community support services agency license, and if required, an assisted living facility license, must provide medication management as required by their license. Other contracted providers do not provide medication management.

Providers holding assisted living facility licenses are required to monitor all aspects of an individual's medication. The provider registered nurse reviews the individual's medications annually and upon significant changes in the individual's condition.

Home and community support services agency licensed providers are required to monitor all aspects of an individual's medication that the provider agency administers.

Contract monitoring does not include a specific component for medication management unless there is a complaint or report of abuse, neglect, or exploitation. DADS Regulatory Services performs licensing surveys that include medication management by the home and community support services agencies and assisted living facilities if the assisted living facility is responsible for management of the medication. DADS Regulatory Services surveys that occur during the waiver year and any contract investigations in response to complaints regarding providers are collected and reported annually. The frequency of licensing surveys varies with each type of license. DADS imposes penalties such as requiring corrective action plans, administrative penalties, and license revocation when harmful medication management practices are detected.

DADS staff follows up to ensure corrective action plans are properly implemented.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

DADS Regulatory Services licenses a DBMD provider as a home and community support services agency and, if necessary, as an assisted living facility. Medication management is part of the license requirements for these providers. DADS Regulatory Services surveyors monitor home and community support services agencies and assisted living facilities for compliance with licensing requirements. DADS Regulatory Services surveyors and contract monitoring staff also monitor these entities to ensure the delivery of quality services to individuals. DADS Regulatory Services surveyors and contract monitoring staff conduct follow-up surveys and inspections to ensure the provider has effectively implemented any corrective action plan required due to cited violations.

DADS Regulatory Services surveys home and community support services agencies during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. DADS surveys assisted living facilities biennially. DADS may survey or monitor facilities or home and community support services agencies more frequently if appropriate.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. **Provider Administration of Medications.** *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DBMD providers must administer medications as required by applicable licensure. Licensure regulations only allow licensed nurses, certified medication aides (under the direct supervision of a licensed nurse), or persons who administer medication as a registered nurse-delegated task to administer medications.

A registered nurse who supervises a medication aide or delegates medication administration must provide ongoing supervision and any necessary training to the unlicensed person. Registered nurses must follow procedures for delegation in accordance with Nurse Practice Act.

Licensure regulations require home and community support services agencies to monitor all aspects of an individual's medication, regardless of whether the contracted provider administers the medication or the individual self-administers his or her medication. Licensure regulations require assisted living facilities that are responsible for monitoring of an individual's medication to monitor all aspects of that individual's medication. For individuals residing in an assisted living facility who self-administer their medication and store their medication in their room, the assisted living facility is required to provide monthly medication counseling to the individual.

The home and community support services agencies reviews an individual's medications annually and upon significant change in the individual's condition. The assisted living facility reviews an individual's medications upon significant change in the individual's condition. A significant change to an individual's condition that would require a review of the individual's medication might include a new diagnosis or medication. Home and community support services agencies and assisted living facilities must report to the individual's physician any unusual medication reactions. The provider must also document any time an individual fails to take medication.

iii. Medication Error Reporting. *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the State:

◉ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

Any type of medication error, regardless of severity, must be recorded and the program provider must make information available to DADS upon request during licensure surveys. If a medication error rises to the level of abuse or neglect, the provider must report to DADS based on licensure requirements.

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

DADS is responsible for monitoring compliance with licensing requirements and surveying licensed providers for compliance with licensing requirements on a regular basis. Licensure surveys include a review of medication administration errors.

The home and community support services agencies reviews an individual's medications annually and upon significant change in the individual's condition. The assisted living facility reviews an individual's medications upon significant change in the individual's condition. A significant change to an individual's condition that would require a review of the individual's medication might include a new diagnosis or medication. Home and community support services agencies and assisted living facilities must report to the individual's physician any unusual medication reactions. The provider must also document any time an individual fails to take medication.

DADS Regulatory Services reports the number of validated instances of licensure violations, which includes medication administration errors. The incidence of violations related to medication administration is so low that occurrences are dealt with on a case-by-case basis.

DADS provides quarterly and annual reports to HHSC. All quality issues are discussed during quarterly quality review team meetings. Remediation activities are determined. HHSC and DADS work together to trend and analyze data as part of the new quarterly review process.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.a.1 Number and percent of individuals who are free from confirmed abuse, neglect, or exploitation. N: Number of individuals who are free from confirmed abuse, neglect, or exploitation D: Number of individuals listed as a victim in a report of abuse, neglect, or exploitation

Data Source (Select one):
Other
If 'Other' is selected, specify:
DADS Quality Assurance and Improvement Datamart; DADS Home and Community Support Services Agency Intake and Tracking System; DADS Home and Community Support Services Agency Integrated

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Department of Family and Protective Services	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
G.a.2 Number and percent of individuals reporting they are ever afraid or scared when at home. N: Number of individuals reporting no D: Number of individuals who responded to the question

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Adult Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Biennially	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Biennially

Performance Measure:
G.a.3 Number and percent of individuals reporting they are ever afraid or scared when in their neighborhood N: Number of individuals reporting no D: Number of individuals who responded to the question

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Adult Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Biennially	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Biennially

Performance Measure:
G.a.4 Number and percent of individuals reporting they are ever afraid or scared when at work or at their their day program/other activity. N: Number of individuals reporting no D: Number of individuals who responded to the question

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Adult Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +\- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify:	

	Biennially	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Biennially

Performance Measure:
G.a.5 Number and percent of individuals reporting that if they feel afraid there is someone they can go to for help. N: Number of individuals reporting yes D: Number of individuals who responded to the question

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Adult Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +\- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☑ **Other** Specify: Biennially	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Biennially

Performance Measure:
G.a.6 Number and percent of individuals reporting they are able to go to the doctor. N: Number of individuals reporting yes D: Number of individuals who responded to the question

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Adult Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Biennially	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Biennially

Performance Measure:
G.a.7 Number and percent of priority one complaints resolved by DADS Regulatory Services. N: Number of priority one complaints resolved by DADS Regulatory Services D: Number of priority one complaints received

Data Source (Select one):
Other
If 'Other' is selected, specify:
Health and Human Services Contract Administration and Tracking System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.8 Number and percent of individuals who received information on how to report abuse, neglect, or exploitation. N: Number of individuals who received information on how to report abuse, neglect, or exploitation D: Number of individuals' case records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
DBMD Contracts Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%+/-8.25%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Bienially	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.9 Number and percent of individuals free from an allegation of abuse, neglect, or exploitation. N: Number of individuals without an allegation of abuse, neglect, or exploitation D: Number of enrolled individuals

Data Source (Select one):
Other
If 'Other' is selected, specify:

DADS Quality Assurance and Improvement Datamart; DADS Home and Community Support Services Agency Intake and Tracking System; DADS Home and Community Support Services Agency Integrated

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Department of Family and Protective Services	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Texas Administrative Code requires providers to protect individuals from abuse, neglect or exploitation and to report potential incidents of abuse, neglect or exploitation. Providers are also required by rule to

explain, during the initial face-to-face enrollment meeting and annually thereafter, the procedures for an individual or legally authorized representative to file a complaint regarding a DBMD program provider and to review the individual's rights, which include the right to be free from abuse and neglect.

In accordance with state law, DADS maintains a State Employee Misconduct Registry that includes the names of unlicensed direct care staff DADS or the Department of Family and Protective Services has confirmed to have abused, neglected, or exploited an individual receiving services administered by DADS. In addition, in accordance with federal law, DADS maintains a Nurse Aide Registry that lists certified nurse aides. The Nurse Aide Registry indicates if an aide has been confirmed to have abused, neglected, or exploited a resident of a licensed nursing facility. Providers must consult these registries prior to offering employment to a non-licensed employee and must refrain from employing that person if either registry indicated the person was confirmed to have abused, neglected, or exploited an individual receiving program services.

Providers (home and community support services agencies and assisted living facilities) are required to report allegations of abuse, neglect, and exploitation directly to DADS and the Department of Family and Protective Services immediately upon suspicion of such activities.

During the quarterly monitoring contact, the case manager is responsible for determining if any existing situations jeopardize the individual's health and welfare. Additional contacts may be scheduled to ensure the individual's health and welfare.

DADS requires providers to maintain a complaint log and investigate/resolve complaints according to DADS Community Services complaint procedure rules. Additionally, the Community Services Contracts unit maintains a complaint log for the purpose of collecting, reviewing and reporting complaint or incident information. On a monthly basis, Community Services Contracts staff compiles a Complaint Activity Report and a Complaint Resolution Activity Report and posts the reports internally.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DADS Consumer Rights and Services is the central point of intake for complaints and incidents. Complaints and incidents are entered into DADS' intake tracking database and assigned a priority. After Consumer Rights and Services completes the intake, it is forwarded electronically via the intake tracking system to DADS Regulatory Services-Survey Operations. Complaint and incident intakes involving service provider non-compliance with contract requirements are also referred by Consumer Rights and Services via e-mail to Community Services Contracts staff.

DADS Community Services Contracts staff conducts complaint investigations involving the individual, provider staff, or DADS staff. Depending upon the nature of the complaint, DADS Community Services Contracts staff may also refer the complaint to DADS Regulatory Services, the Department of Family and Protective Services, the Texas Board of Nursing, or local law enforcement agencies. DADS Community Services Contracts staff informs providers of complaint findings at the conclusion of the investigation, including whether the allegations were substantiated. If the investigation findings substantiate an immediate risk to the health or welfare of a waiver individual, the provider is required to take immediate action to resolve the situation. The provider is also required to develop and implement an immediate corrective action plan addressing the prevention of future occurrences of the situation or similar events. The purpose of the immediate corrective action plan is for the provider to communicate in writing the specific action taken to resolve the identified situation and the steps that will be taken to ensure the continued health and safety of the individuals served. The immediate corrective action plan must include the following elements:

- A description of the health and safety issue;
- Action taken to resolve the issue; and
- A plan to prevent the occurrence of the issue.

DADS Community Services Contracts staff does not investigate abuse, neglect, or exploitation. Allegations of this nature are handled in accordance with Title 2 of the Texas Human Resource Code, Subtitle D, Chapter 48, Subchapter G, Section 48.303 and the Memorandum of Understanding between DADS and the

Department of Family and Protective Services. If at any time during the course of the investigation, Community Services Contracts staff becomes aware of an immediate threat to an individual's health and safety or abuse, neglect, or exploitation, staff must report the situation within one hour to:

- DADS - Consumer Rights and Services;
- Department of Family and Protective Services;
- DADS - Regulatory Services; and
- DADS - Community Services Contracts manager or manager's designee.

The Department of Family and Protective Services and DADS share statutory authority and responsibility to investigate reported incidents and complaints involving abuse, neglect or exploitation of an individual receiving DBMD services by a facility or agency employee, volunteer or contractor under memorandums of understanding between the two departments. In addition, facilities and agencies are required, by rule, to conduct an investigation of allegations of abuse, neglect, and exploitation. The Department of Family and Protective Services section records and tracks abuse, neglect, and exploitation reports in its Information Management Protecting Adults and Children in Texas system. DADS staff coordinates with Department of Family and Protective Services staff to determine the resolution of abuse, neglect or exploitation allegations.

During contract monitoring reviews, DADS Community Services Contracts staff confirms that the individual and legally authorized representative has been informed of the complaint procedures and the process for reporting abuse, neglect and exploitation. Providers that are unable to show evidence to support this requirement are cited and required to develop a corrective action plan and may receive other sanctions. DADS Sanction Action Review Committee reviews all substantiated allegations of contract non-compliance. The Sanction Action Review Committee review may result in a corrective action plan or sanction, such as suspension of individual referrals, holding vendor payments, suspension, or termination of the provider contract.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

HHSC and DADS have articulated the vision and infrastructure for the quality improvement strategy for the waivers operated by DADS in the Quality Oversight Plan, which was approved by both agencies' commissioners in 2010. Central to this plan is the Quality Review Team, which consists of representatives from several agencies within the HHS enterprise. In addition to directing the improvement activities for each waiver, the Quality Review Team oversees implementation of the Quality Oversight Plan and related processes. This includes making recommendations for new or revised quality measures, identifying and facilitating access to new data sources, identifying new intra and inter-agency processes impacting any and all phases of the quality program, approving and monitoring all active quality improvement projects, and other actions needed to assure continued improvement of Texas' home and community-based services waiver programs. Additionally, the Quality Review Team will review the Quality Oversight Plan at least every three years. Revisions to the plan will be approved by HHSC leadership.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The Quality Review Team meets quarterly and reviews comprehensive quality reports from each waiver program at least annually. These reports are generated from the DADS Center for Policy and Innovation Quality Assurance and Improvement Data Mart that includes data on all of the waiver's quality improvement strategy measures. These reports also include remediation activities and outcomes. HHSC and DADS staff present the reports and recommendations to the Quality Review Team. Priorities are established by the Quality Review Team. Improvement plans are developed as issues are identified and the Quality Review Team reviews, modifies, if needed, and approves all improvement plans. All active improvement plans for all waivers are monitored at each quality review team meeting, to include updates on data to determine whether or not improvement activities have had the intended effect. The Quality Assurance and Improvement Data Mart compiles data currently collected in multiple automated systems. The Data Mart produces standardized reports and provides capability for ad-hoc reporting. The areas covered by the reports include: individual demographics; service utilization; enrollments; levels of care; service plans; consumer-direction; critical incidents; provider compliance and oversight; transfers; and discharges. This system has the capability to provide management reports at the individual level or any level of aggregation needed.

To facilitate communication with external stakeholders, the agency has implemented Texas Quality Matters, which is a web-based medium that provides external stakeholders with an increased ability to access quality reporting information. Texas Quality Matters provides the State with the ability to conduct online surveys related to quality improvement. Stakeholders have the opportunity to provide testimony on policies and rules governing the delivery of services in the DBMD program in writing and at meetings of the Medical Care Advisory Committee, the DADS Advisory Council, and the HHSC Advisory Council. DADS posts announcements for all stakeholder meetings on the DADS website at least 30 days prior to the meeting.

The Promoting Independence Advisory Committee is comprised of member representatives from all departments of the State Medicaid agency and external stakeholders. The Promoting Independence Advisory Committee studies and makes recommendations to the State regarding appropriate care settings for persons with disabilities.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

At least every three years, DADS and HHSC staff will evaluate the processes and indicators of the Quality Oversight Plan. Staff will examine issues such as whether or not the indicators are providing substantive information about each sub-assurance and whether the Quality Review Team composition is inclusive of key agency stakeholders. If areas for improvement exist, staff will make recommendations for changes to the Quality Review Team and the Quality Review Team will approve or revise staff's recommended changes.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DADS uses a fiscal monitoring process and billing and payment reviews to ensure that DBMD providers and financial management services agencies are complying with program requirements. DADS conducts fiscal monitoring of DBMD providers on-site at least every two years and typically reviews a two-month sample of the provider's records. At a minimum of every three years, financial management services agencies are monitored with typically a six-month sample of financial management services agencies' records reviewed. DADS may lengthen that sample period if deemed necessary. The methods used in the monitoring process include:

- Review of the provider's existing billing system and internal controls;
- Comparison of the provider's or financial management services agency's service delivery records with its billing records to verify that the payments DADS made to the provider or financial management services agency were appropriate;
- Review of service plans and records; and
- Comparison of service delivery and other supporting documentation with individual plans of care.

DADS may perform desk and on-site compliance reviews associated with claims the provider submits under a contract. DADS recovers improper payments, without extrapolation, when DADS verifies that the provider has been overpaid because of improper billing or accounting practices or for failure to comply with the contract terms.

The provider must provide the information DADS requests that supports the claims information the provider reported. If the provider fails to provide the requested information, DADS may take adverse action against the provider contract.

DADS may withhold the provider's payments and apply them to the billing and payment review exception for any payments the provider owes DADS and may require corrective action for any billing and payment finding.

Provider agencies are not required to conduct independent financial audits. The Texas State Auditor's Office is responsible for the statewide financial and compliance audit. The HHSC Office of the Inspector General is responsible for performing audits of contracts between DADS and providers.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I.a.1 Number and percent of provider claims that are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. N: Number of provider claims that are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver D: number of provider claims

Data Source (Select one):
Other
If 'Other' is selected, specify:
Claims Management System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
For waiver services delivered through the agency option and the consumer directed services option, providers and financial management services agencies send claims for reimbursement for waiver services provided to individuals to the State's contracted Medicaid Management Information System, currently the Texas Medicaid and Healthcare Partnership. Providers may submit claims electronically via the Texas Medicaid Healthcare Partnership or they may submit paper claims.

The Claims Management System verifies that an individual was Medicaid eligible on the date of service delivery specified in a request for reimbursement and allows payment only for claims for services provided within the eligibility period. The Claims Management System will reject provider claims if the Service Authorization System does not reflect that the waiver individual meets eligibility criteria. The Claims Management System automatically rejects any claim entered for a service not authorized on an individual's service plan as authorized in the Service Authorization System. The Claims Management System also automatically rejects any claim that is entered with an unauthorized billing code.

The State's Claims Management System is a comprehensive claims processing system for providers. This system has numerous edits to assure that providers submit accurate billings. Providers are unable to submit billing claims for any service components until DADS has authorized the service plan and the authorized service plan has been entered into the Service Authorization System.

The Claims Management System also edits claims for the validity of the information and compliance with business rules for the service and program and calculates the payment amount and applicable reductions for claims approved for payments. Prior to issuing payment, the automated claims management system verifies that an individual's current authorized individual service plan has sufficient units to cover amounts claimed and prevents duplicate claims for services already paid.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
During on-site monitoring reviews, DADS Community Services Contracts staff determines a provider's compliance with standards pertaining to fiscal accountability and verifies that the services billed were actually rendered. As part of the fiscal component of biennial on-site monitoring reviews, DADS Community Services Contracts staff verifies that billings submitted to and paid by DADS are for billable time and activities by verifying that billing forms are completed according to DADS' instructions.

Providers must maintain documentation supporting the claims. If the provider fails to maintain the required documentation, DADS recovers improper payments. DADS also recovers payments when Community Services Contracts staff verifies the provider was overpaid because of improper billing. The State has mechanisms in place for the return to the Centers for Medicare & Medicaid Services of any federal matching funds received for improper billing.

DADS Community Services Contracts staff prepares a written report itemizing claims found in error during each review. A summary of each review, including the name of the provider, the dollar amount to be subtracted from pending or future payments to the provider, if applicable, and any follow-up action to be taken, is scanned and is sent electronically on a monthly basis to the DADS Contract Oversight and Support area. DADS Contract Oversight and Support staff enters provider monitoring information into the Health and Human Services Contracts Administration and Tracking System. DADS Contract Oversight and Support staff uses the data entered into this system to track monitoring. DADS Community Services Contracts staff conducts follow-up monitoring visits to ensure that the provider has taken the necessary steps to attain and maintain compliance at the required performance level.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

HHSC, the State Medicaid Agency, determines payment rates every two years. Payment rates are determined for each service. The rates for services are prospective and uniform statewide. HHSC determines payment rates after analysis of financial and statistical information, and the effect of the payment rates on achievement of program objectives, including economic conditions and budgetary considerations. Texas uses existing service rate methodologies from other HCBS waivers to set service rates for DBMD. The rates for the DBMD program are available on the HHSC Rate Analysis webpage.

HHSC models the rates for the following services from other Medicaid HCBS waiver programs that use cost reports to determine rates: day habilitation; residential habilitation; respite services in the individual's or respite provider's private residence; respite services in an intermediate care facility; respite in an assisted living home; respite in a camp; supported employment; audiology services; behavioral support; chore service; dietary services; employment assistance; intervener; nursing services; occupational therapy services; physical therapy services; and speech, hearing and language therapy services.

Providers of these services are required to submit annual cost reports to the HHSC Rate Analysis Department. Providers are responsible for eliminating all unallowable expenses from the cost report prior to submission of the cost report. The HHSC Office of Inspector General completes a desk a sample of cost reports, with a subgroup of cost reports audited on-site. The Office of Inspector General removes any unallowable costs and

corrects any errors detected on the cost report in the course of the review or on-site audit. Audited cost reports are used in the determination of statewide prospective rates.

In general, recommended unit of service rates for each service are determined as follows: 1) total allowable costs for each provider are determined from the audited cost report; 2) each provider's total allowable costs are projected from the historical cost reporting period to the prospective reimbursement period; 3) payroll taxes and benefits are allocated to each salary item; 4) total projected allowable costs are divided by the number of units of service to determine the projected cost per unit of service; 5) the allowable costs per unit of service for each contracted provider are arrayed and weighted by the number of units of service and the median cost per unit of service is calculated; and 6) the median cost per unit of service for each waiver service is multiplied by 1.044.

Prescription drugs are paid at cost.

When comparable services do not currently exist, reimbursement rates will be determined using a pro forma approach. This approach involves using historical costs of delivering similar services, where appropriate data are available, and estimating the basic types and costs of products and services necessary to deliver services meeting federal and state requirements to set waiver rates. HHSC models rates as specified below.

The rate for case management is determined by modeling the salary for a case manager staff position. This rate is periodically updated for inflation.

The rates for assisted living are determined by modeling using a pro forma approach.

The rate for orientation and mobility services is determined by modeling the salary for an orientation and mobility staff position. This rate is updated periodically for inflation.

Minor home modifications, adaptive aids and medical supplies, and dental are paid at cost. The DBMD providers are given additional payments for the cost of acquiring these services for participants; these payments are called requisition fees. The rates for the requisition fees are modeled using a pro forma approach.

The rates for support consultation, Intervener I, Intervener II, Intervener III and transition assistance services are determined by modeling the estimated salary for a person with similar skills and training requirements. These rates are updated periodically for inflation.

In setting the rates for financial management services provided under the consumer directed services option, the reimbursement rate to the financial management services provider, the financial management services agency, is a flat monthly fee determined by modeling the estimated cost to carry out the financial management responsibilities of the financial management services agency. The payment rate available for the individual's budget for the self-directed service is modeled based on the payment rate to the traditional agency less an adjustment for the traditional agency's indirect costs.

HHSC holds a public hearing before it approves rates. The purpose of the hearing is to give interested parties an opportunity to comment on the proposed rates. Notice of the hearing is provided to the public. The notice of the public hearing includes information about the proposed rate changes and identifies the name, address, and telephone number of the staff member to contact for the materials pertinent to the proposed rates. At least 10 working days before the public hearing takes place, material pertinent to the proposed statewide uniform rates is made available to the public. The public may present comments at the hearing or submit written comments regarding the proposed rates. Information about payment rates is made available to waiver participants through HHSC and DADS websites as well as through the Texas Register via a public notice.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

For services delivered through the agency option and consumer directed services option, providers submit claims for reimbursement for waiver services provided to individuals to the CMS-approved State Medicaid Management Information System. Providers may submit claims electronically or may submit paper claims to the Medicaid Management Information System.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The State's contracted Medicaid Management Information System is the claims processing system that verifies that an individual was Medicaid-eligible on the date of service delivery specified in a request for reimbursement and allows payment only on claims for services provided within the eligibility period.

Prior to processing claims, the automated claims management system edits claims for the validity of the information and compliance with business rules for the service and program, and calculates the payment amount and applicable reductions for claims approved for payment. For example, unless the system verifies that an individual's current authorized service plan has sufficient units to cover amounts claimed or that an authorized level of care is registered in the claims management system, the claim will be rejected.

As noted in the Financial Integrity and Accountability section above, DADS staff conducts on-site reviews to determine a provider's compliance with standards pertaining to fiscal accountability and to verify the services billed were actually rendered.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (●) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. **Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ◉ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ○ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ○ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

○ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

◉ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

○ **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☐ **Appropriation of State Tax Revenues to the State Medicaid agency**

☑ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

The non-federal share to draw down the federal funds is appropriated to DADS for the DBMD program. The non-federal share of DBMD waiver program funds are appropriated by the Texas State Legislature to DADS, the department designated by HHSC, the single State Medicaid Agency, as the Medicaid operating agency for the DBMD waiver program. There are no inter-governmental transfers or certified public expenditures.

The non-federal share is exclusively from State general revenue appropriations. There are no local sources of funds or certified public expenditures. DBMD waiver non-federal share funds are appropriated to DADS as a

specific line item for the provision of DBMD waiver services. If another agency were designated to operate the DBMD waiver program, those funds would be removed from DADS and appropriated to that agency. DADS DBMD waiver program appropriations remain in the state comptroller's account designated for the DBMD waiver program. Once the Medicaid agency has approved a claim via the Health and Human Services Accounting System, federal funds are drawn and combined with the state appropriation to make payments to the provider.

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

○ **The following source(s) are used**

Check each that applies:

- ☐ **Health care-related taxes or fees**
- ☐ **Provider-related donations**
- ☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Payment of the cost for room and board is the responsibility of the participant except when room and board are provided under the waiver as part of out-of-home respite services. The costs for room and board are excluded from the rates for assisted living services.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	43694.27	3839.24	47533.51	93223.81	2596.78	95820.59	48287.08
2	42550.14	3832.59	46382.73	95060.32	2726.62	97786.94	51404.21
3	50373.99	5156.09	55530.08	96828.44	2862.95	99691.39	44161.31
4	51258.54	5413.90	56672.44	98581.03	3006.10	101587.13	44914.69
5	52302.20	5684.54	57986.74	100365.35	3156.41	103521.76	45535.02

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care: ICF/IID
Year 1	192	192
Year 2	218	218
Year 3	218	218
Year 4	218	218
Year 5	218	218

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Calculation of C
Texas Deaf-Blind Waiver Renewal

	Monthly turnover Rate	Mar 13-Feb 14 Year 1	Mar 14-Feb 15 Year 2	Mar 15-Feb 16 Year 3	Mar 16-Feb 17 Year 4	Mar 17-Feb 18 Year 5
Deaf-Blind Waiver						
Avg clients/month		180	206	206	206	206
Est End of Year (EOY) clients/month			192	206	206	206	206
Clients added during year	0.0017		12	12	12	12	12
Annual Unduplicated Clients (EOY + clients added)			192	218	218	218	218
Total Client Months		1948	2102	2472	2472	2472	
Length of stay (months)		10.15	9.64	11.34	11.34	11.34	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Explanation of D.—For all services but "prescriptions over 3 per month", the utilization, units of service and costs per unit of service estimates were based upon claims data experience for Fiscal Year 2012 (payments through August 2012). In order to account for payment lag, we used the average monthly utilization, units of service per utilizer and costs per unit for the period September 2011 through May 2012. For all services except drugs, assumed Personal Consumption Expenditure (PCE) "General" chained price deflators of: 0% for Waiver renewal year 1 (March 2013-February 2014), 2.0% for renewal year 2, 2.0% for renewal year 3, 2.0% for renewal year 4, and 2.0% for renewal year 5.
For "prescriptions over 3 per month", the estimates were based upon claims payment data used to prepare the DBMD CMS 372 report for Waiver year March 2011-February 2012. Assumed inflators of: 5.0% for March 2012-Feb 2013, 5.0% for Waiver renewal year 1 (March 2013-February 2014), 5.0% for renewal year 2, 5.0% for renewal year 3, 5.0% for renewal year 4, and 5.0% for renewal year 5.

Since September 1, 2014, unlimited prescription drugs have been provided to all DBMD individuals through managed care. Thus, for Waiver Years 4 and 5, 44.1% of the costs associated with "Extended State Plan: Prescriptions" were removed from D costs and included as D' costs. 55.9% of the costs associated with "Extended State Plan: Prescriptions" remain under the waiver for dual-eligible individuals.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates were based upon claims payment data used to prepare the DBMD CMS 372 report for Waiver year March 2011-February 2012. For non-drug expenditures as well as drug expenditures, assumed inflators of: 5.0% for March 2012-Feb 2013, 5.0% for Waiver renewal year 1 (March 2013-February 2014), 5.0% for renewal year 2, 5.0% for renewal year 3, 5.0% for renewal year 4, and 5.0% for renewal year 5.

Since September 1, 2014, unlimited prescriptions drugs have been provided to all DBMD waiver individuals through managed care. Thus for Waiver Year 4 and 5, 44.1% of the costs associated with "Extended State Plan: Prescriptions" were removed from D costs and were included as D' costs. 55.9% of the costs associated with "State Plan: Prescriptions" remain under the waiver for dual-eligible individuals.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates were based upon claims payment data for FY 2010 for the institutional ICF/ID population. Assumed Personal Consumption Expenditure (PCE) "General" chained price deflators of: 2.44% for March 2010-February 2011, 1.26% for March 2011-Feb 2012, 1.54% for March 2012-Feb 2013, 1.9% for Waiver renewal year 1 (March 2013-February 2014), 1.97% for renewal year 2, 1.86% for renewal year 3, 1.81% for renewal year 4, and 1.81% for renewal year 5.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates were based upon claims payment data for FY 2010 for the institutional ICF/ID population. Assumed PCE "Health Consumption" price deflators of: 1.97% for March 2010-February 2011, 2.25% for March 2011-Feb 2012, 5.0% for March 2012-Feb 2013, 5.0% for Waiver renewal year 1 (March 2013-February 2014), 5.0% for renewal year 2, 5.0% for renewal year 3, 5.0% for renewal year 4, and 5.0% for renewal year 5.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Case Management	
Day Habilitation	
Residential Habilitation	
Respite	
Supported Employment	
Prescribed Drugs	
Financial Management Services	
Support Consultation	
Adaptive Aids and Medical Supplies	
Assisted Living	
Audiology Services	
Behavioral Support	
Chore Service	
Dental Treatment	
Dietary Services	
Employment Assistance	
Intervener	
Minor Home Modifications	
Nursing	
Occupational Therapy Services	
Orientation and Mobility	
Physical Therapy Services	
Speech, Hearing, and Language Therapy Services	
Transition Assistance Services	

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**139194.00**
Case Management	Hourly	185	20.00	37.62	**139194.00**	
Day Habilitation Total:						**221659.20**
Day Habilitation	Hourly	21	720.00	14.66	**221659.20**	
Residential Habilitation Total:						**2807100.15**
Consumer Directed Residential Habilitation	Hourly	5	2955.00	13.05	**192813.75**	
Residential Habilitation	Hourly	80	2211.00	14.78	**2614286.40**	
Respite Total:						**172180.88**
Consumer Directed Respite	Daily	2	19.00	214.60	**8154.80**	
Respite	Daily	43	16.00	238.41	**164026.08**	
Supported Employment Total:						**26471.20**
Consumer Directed Supported Employment	Hourly	1	406.00	32.10	**13032.60**	
Supported Employment	Hourly	1	406.00	33.10	**13438.60**	
Prescribed Drugs Total:						**164568.88**
Prescribed Drugs	Per Rx	76	14.00	154.67	**164568.88**	
Financial Management Services Total:						**12120.00**
Financial Management Services	Monthly	5	12.00	202.00	**12120.00**	
Support Consultation Total:						**630.17**
Support Consultation	Hourly	1	41.00	15.37	**630.17**	
			GRAND TOTAL:			**8389299.79**
			Total Estimated Unduplicated Participants:			**192**
			Factor D (Divide total by number of participants):			**43694.27**
			Average Length of Stay on the Waiver:			309

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adaptive Aids and Medical Supplies Total:						**15318.60**
Adaptive Aids and Medical Supplies	Per Item	55	4.00	69.63	**15318.60**	
Assisted Living Total:						**3741871.35**
18 hour assisted living	Daily	7	95.00	113.19	**75271.35**	
24 hour assisted living	Daily	96	291.00	131.25	**3666600.00**	
Audiology Services Total:						**2161.93**
Audiology Services	Hourly	1	41.00	52.73	**2161.93**	
Behavioral Support Total:						**50581.08**
Behavioral Support	Hourly	53	12.00	79.53	**50581.08**	
Chore Service Total:						**22195.20**
Chore Service	Hourly	4	480.00	11.56	**22195.20**	
Dental Treatment Total:						**30095.91**
Dental Treatment	Per Treatment	87	1.00	345.93	**30095.91**	
Dietary Services Total:						**1105.60**
Dietary Services	Hourly	1	20.00	55.28	**1105.60**	
Employment Assistance Total:						**26471.20**
Consumer Directed Employment Assistance	Hourly	1	406.00	32.10	**13032.60**	
Employment Assistance	Hourly	1	406.00	33.10	**13438.60**	
Intervener Total:						**752046.61**
Consumer Directed Intervener	Hourly	1	2760.00	17.28	**47692.80**	
Intervener	Hourly	55	584.00	16.97	**545076.40**	
Intervener I	Hourly	1	747.00	21.53	**16082.91**	
Intervener II	Hourly	1	747.00	25.61	**19130.67**	
Intervener III	Hourly	1	747.00	29.69	**22178.43**	
					28331.40	

GRAND TOTAL:	**8389299.79**
Total Estimated Unduplicated Participants:	**192**
Factor D (Divide total by number of participants):	**43694.27**
Average Length of Stay on the Waiver:	309

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consumer Directed Intervener I	Hourly	1	1380.00	20.53		
Consumer Directed Intervener II	Hourly	1	1380.00	24.61	33961.80	
Consumer Directed Intervener III	Hourly	1	1380.00	28.69	39592.20	
Minor Home Modifications Total:						3704.10
Minor Home Modifications	Per Item	2	5.00	370.41	3704.10	
Nursing Total:						156330.00
Nursing	Hourly	150	27.00	38.60	156330.00	
Occupational Therapy Services Total:						14298.20
Occupational Therapy Services	Hourly	4	49.00	72.95	14298.20	
Orientation and Mobility Total:						1663.37
Orientation and Mobility	Hourly	1	41.00	40.57	1663.37	
Physical Therapy Services Total:						11459.64
Physical Therapy Services	Hourly	2	74.00	77.43	11459.64	
Speech, Hearing, and Language Therapy Services Total:						14342.52
Speech/Hearing/Language	Hourly	2	94.00	76.29	14342.52	
Transition Assistance Services Total:						1730.00
Transition Assistance Services	Per item	1	1.00	1730.00	1730.00	
			GRAND TOTAL:			8389299.79
			Total Estimated Unduplicated Participants:			192
			Factor D (Divide total by number of participants):			43694.27
			Average Length of Stay on the Waiver:			309

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**150103.80**
Case Management	Hourly	210	19.00	37.62	**150103.80**	
Day Habilitation Total:						**237140.16**
Day Habilitation	Hourly	24	674.00	14.66	**237140.16**	
Residential Habilitation Total:						**3059814.98**
Consumer Directed Residential Habilitation	Hourly	6	2731.00	13.05	**213837.30**	
Residential Habilitation	Hourly	91	2116.00	14.78	**2845977.68**	
Respite Total:						**194639.04**
Consumer Directed Respite	Daily	3	12.00	214.60	**7725.60**	
Respite	Daily	49	16.00	238.41	**186913.44**	
Supported Employment Total:						**50334.40**
Consumer Directed Supported Employment	Hourly	1	772.00	32.10	**24781.20**	
Supported Employment	Hourly	1	772.00	33.10	**25553.20**	
Prescribed Drugs Total:						**197803.20**
Prescribed Drugs	Per Rx	87	14.00	162.40	**197803.20**	
Financial Management Services Total:						**13332.00**
Financial Management Services	Montly	6	11.00	202.00	**13332.00**	
Support Consultation Total:						**1183.49**
Support Consultation	Monthly	1	77.00	15.37	**1183.49**	
Adaptive Aids and Medical Supplies Total:						**17897.04**
Adaptive Aids and Medical Supplies	Per Item	63	4.00	71.02	**17897.04**	
Assisted Living Total:						**4023865.23**
18 hour assisted living	Daily	8	99.00	113.19	**89646.48**	
24 hour assisted living	Daily	109	275.00	131.25	**3934218.75**	
Audiology Services Total:						

GRAND TOTAL:	**9275929.88**
Total Estimated Unduplicated Participants:	**218**
Factor D (Divide total by number of participants):	**42550.14**
Average Length of Stay on the Waiver:	294

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						2056.47
Audiology Services	Hourly	1	39.00	52.73	2056.47	
Behavioral Support Total:						52489.80
Behavioral Support	Hourly	60	11.00	79.53	52489.80	
Chore Service Total:						21085.44
Chore Service	Hourly	4	456.00	11.56	21085.44	
Dental Treatment Total:						34932.15
Dental Treatment	Per Treatment	99	1.00	352.85	34932.15	
Dietary Services Total:						1050.32
Dietary Services	Hourly	1	19.00	55.28	1050.32	
Employment Assistance Total:						50334.40
Consumer Directed Employment Assistance	Hourly	1	772.00	32.10	24781.20	
Employment Assistance	Hourly	1	772.00	33.10	25553.20	
Intervener Total:						939542.73
Consumer Directed Intervener	Hourly	1	2624.00	17.28	45342.72	
Intervener	Hourly	63	553.00	16.97	591217.83	
Intervener I	Hourly	2	711.00	21.53	30615.66	
Intervener II	Hourly	2	711.00	25.61	36417.42	
Intervener III	Hourly	2	711.00	29.69	42219.18	
Consumer Directed Intervener I	Hourly	2	1312.00	20.53	53870.72	
Consumer Directed Intervener II	Hourly	2	1312.00	24.61	64576.64	
Consumer Directed Intervener III	Hourly	2	1312.00	28.69	75282.56	
Minor Home Modifications Total:						3400.38
Minor Home Modifications	Per Item	3	3.00	377.82	3400.38	

GRAND TOTAL:	9275929.88
Total Estimated Unduplicated Participants:	218
Factor D (Divide total by number of participants):	42550.14
Average Length of Stay on the Waiver:	294

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nursing Total:						**170612.00**
Nursing	Hourly	170	26.00	38.60	**170612.00**	
Occupational Therapy Services Total:						**20426.00**
Occupational Therapy Services	Hourly	4	70.00	72.95	**20426.00**	
Orientation and Mobility Total:						**3123.89**
Orientation and Mobility	Hourly	1	77.00	40.57	**3123.89**	
Physical Therapy Services Total:						**10917.63**
Physical Therapy Services	Hourly	3	47.00	77.43	**10917.63**	
Speech, Hearing, and Language Therapy Services Total:						**18080.73**
Speech/Hearing/Language	Hourly	3	79.00	76.29	**18080.73**	
Transition Assistance Services Total:						**1764.60**
Transition Assistance Services	Per item	1	1.00	1764.60	**1764.60**	
				GRAND TOTAL:		**9275929.88**
				Total Estimated Unduplicated Participants:		**218**
				Factor D (Divide total by number of participants):		**42550.14**
				Average Length of Stay on the Waiver:		294

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**185327.10**
Case Management	Hourly	210	23.00	38.37	**185327.10**	
Day Habilitation Total:						**284169.60**
Day Habilitation					**284169.60**	
				GRAND TOTAL:		**10981529.65**
				Total Estimated Unduplicated Participants:		**218**
				Factor D (Divide total by number of participants):		**50373.99**
				Average Length of Stay on the Waiver:		345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Hourly	24	792.00	14.95		
Residential Habilitation Total:						**3667838.68**
Consumer Directed Residential Habilitation	Hourly	6	3210.00	13.31	**256350.60**	
Residential Habilitation	Hourly	91	2486.00	15.08	**3411488.08**	
Respite Total:						**223678.14**
Consumer Directed Respite	Daily	3	14.00	218.89	**9193.38**	
Respite	Daily	49	18.00	243.18	**214484.76**	
Supported Employment Total:						**60315.50**
Consumer Directed Supported Employment	Hourly	1	907.00	32.74	**29695.18**	
Supported Employment	Hourly	1	907.00	33.76	**30620.32**	
Prescribed Drugs Total:						**114589.44**
Prescribed Drugs	Per Rx	48	14.00	170.52	**114589.44**	
Financial Management Services Total:						**16071.12**
Financial Management Services	Monthly	6	13.00	206.04	**16071.12**	
Support Consultation Total:						**1426.88**
Support Consultation	Monthly	1	91.00	15.68	**1426.88**	
Adaptive Aids and Medical Supplies Total:						**22818.60**
Adaptive Aids and Medical Supplies	Per Item	63	5.00	72.44	**22818.60**	
Assisted Living Total:						**4820650.76**
18 hour assisted living	Daily	8	116.00	115.45	**107137.60**	
24 hour assisted living	Daily	109	323.00	133.88	**4713513.16**	
Audiology Services Total:						**2420.10**
Audiology Services	Hourly	1	45.00	53.78	**2420.10**	
Behavioral Support Total:						**63273.60**
Behavioral Support	Hourly	60	13.00	81.12	**63273.60**	

GRAND TOTAL:	**10981529.65**
Total Estimated Unduplicated Participants:	**218**
Factor D (Divide total by number of participants):	**50373.99**
Average Length of Stay on the Waiver:	345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Chore Service Total:						**25277.76**
Chore Service	Hourly	4	536.00	11.79	**25277.76**	
Dental Treatment Total:						**35631.09**
Dental Treatment	Per Treatment	99	1.00	359.91	**35631.09**	
Dietary Services Total:						**1296.97**
Dietary Services	Hourly	1	23.00	56.39	**1296.97**	
Employment Assistance Total:						**60315.50**
Consumer Directed Employment Assistance	Hourly	1	907.00	32.74	**29695.18**	
Employment Assistance	Hourly	1	907.00	33.76	**30620.32**	
Intervener Total:						**1126301.82**
Consumer Directed Intervener	Hourly	1	3084.00	17.63	**54370.92**	
Intervener	Hourly	63	650.00	17.31	**708844.50**	
Intervener I	Hourly	2	835.00	21.96	**36673.20**	
Intervener II	Hourly	2	835.00	26.12	**43620.40**	
Intervener III	Hourly	2	835.00	30.28	**50567.60**	
Consumer Directed Intervener I	Hourly	2	1542.00	20.94	**64578.96**	
Consumer Directed Intervener II	Hourly	2	1542.00	25.10	**77408.40**	
Consumer Directed Intervener III	Hourly	2	1542.00	29.26	**90237.84**	
Minor Home Modifications Total:						**4624.56**
Minor Home Modifications	Per Item	3	4.00	385.38	**4624.56**	
Nursing Total:						**200787.00**
Nursing	Hourly	170	30.00	39.37	**200787.00**	
Occupational Therapy Services Total:						**24406.48**
Occupational Therapy Services	Hourly	4	82.00	74.41	**24406.48**	

GRAND TOTAL:	**10981529.65**
Total Estimated Unduplicated Participants:	**218**
Factor D (Divide total by number of participants):	**50373.99**
Average Length of Stay on the Waiver:	345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Orientation and Mobility Total:						**3765.58**
Orientation and Mobility	Hourly	1	91.00	41.38	**3765.58**	
Physical Therapy Services Total:						**13031.70**
Physical Therapy Services	Hourly	3	55.00	78.98	**13031.70**	
Speech, Hearing, and Language Therapy Services Total:						**21711.78**
Speech/Hearing/Language	Hourly	3	93.00	77.82	**21711.78**	
Transition Assistance Services Total:						**1799.89**
Transition Assistance Services	Per item	1	1.00	1799.89	**1799.89**	
				GRAND TOTAL:		**10981529.65**
				Total Estimated Unduplicated Participants:		**218**
				Factor D (Divide total by number of participants):		**50373.99**
				Average Length of Stay on the Waiver:		345

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**189046.20**
Case Management	Hourly	210	23.00	39.14	**189046.20**	
Day Habilitation Total:						**289872.00**
Day Habilitation	Hourly	24	792.00	15.25	**289872.00**	
Residential Habilitation Total:						**3740906.68**
Consumer Directed Residential Habilitation	Hourly	6	3210.00	13.58	**261550.80**	
Residential Habilitation	Hourly	91	2486.00	15.38	**3479355.88**	
				GRAND TOTAL:		**11174361.73**
				Total Estimated Unduplicated Participants:		**218**
				Factor D (Divide total by number of participants):		**51258.54**
				Average Length of Stay on the Waiver:		345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						**228148.62**
Consumer Directed Respite	Daily	3	14.00	223.27	**9377.34**	
Respite	Daily	49	18.00	248.04	**218771.28**	
Supported Employment Total:						**46396.14**
Consumer Directed Supported Employment	Hourly	1	454.00	33.39	**15159.06**	
Supported Employment	Hourly	1	907.00	34.44	**31237.08**	
Prescribed Drugs Total:						**120321.60**
Prescribed Drugs	Per Rx	48	14.00	179.05	**120321.60**	
Financial Management Services Total:						**16392.48**
Financial Management Services	Monthly	6	13.00	210.16	**16392.48**	
Support Consultation Total:						**1455.09**
Support Consultation	Monthly	1	91.00	15.99	**1455.09**	
Adaptive Aids and Medical Supplies Total:						**23275.35**
Adaptive Aids and Medical Supplies	Per Item	63	5.00	73.89	**23275.35**	
Assisted Living Total:						**4917149.20**
18 hour assisted living	Daily	8	116.00	117.76	**109281.28**	
24 hour assisted living	Daily	109	323.00	136.56	**4807867.92**	
Audiology Services Total:						**2468.70**
Audiology Services	Hourly	1	45.00	54.86	**2468.70**	
Behavioral Support Total:						**64537.20**
Behavioral Support	Hourly	60	13.00	82.74	**64537.20**	
Chore Service Total:						**25792.32**
Chore Service	Hourly	4	536.00	12.03	**25792.32**	
Dental Treatment Total:						**36343.89**
Dental Treatment	Per Treatment	99	1.00	367.11	**36343.89**	
				GRAND TOTAL:		**11174361.73**
				Total Estimated Unduplicated Participants:		**218**
				Factor D (Divide total by number of participants):		**51258.54**
				Average Length of Stay on the Waiver:		345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Dietary Services Total:						**1322.96**
Dietary Services	Hourly	1	23.00	57.52	**1322.96**	
Employment Assistance Total:						**46396.14**
Consumer Directed Employment Assistance	Hourly	1	454.00	33.39	**15159.06**	
Employment Assistance	Hourly	1	907.00	34.44	**31237.08**	
Intervener Total:						**1148992.46**
Consumer Directed Intervener	Hourly	1	3084.00	17.98	**55450.32**	
Intervener	Hourly	63	650.00	17.66	**723177.00**	
Intervener I	Hourly	2	835.00	22.40	**37408.00**	
Intervener II	Hourly	2	835.00	26.64	**44488.80**	
Intervener III	Hourly	2	835.00	30.89	**51586.30**	
Consumer Directed Intervener I	Hourly	2	1542.00	21.36	**65874.24**	
Consumer Directed Intervener II	Hourly	2	1542.00	25.60	**78950.40**	
Consumer Directed Intervener III	Hourly	2	1542.00	29.85	**92057.40**	
Minor Home Modifications Total:						**4717.08**
Minor Home Modifications	Per Item	3	4.00	393.09	**4717.08**	
Nursing Total:						**204816.00**
Nursing	Hourly	170	30.00	40.16	**204816.00**	
Occupational Therapy Services Total:						**24895.20**
Occupational Therapy Services	Hourly	4	82.00	75.90	**24895.20**	
Orientation and Mobility Total:						**3841.11**
Orientation and Mobility	Hourly	1	91.00	42.21	**3841.11**	
Physical Therapy Services Total:						**13292.40**
Physical Therapy Services	Hourly	3	55.00	80.56	**13292.40**	

GRAND TOTAL:	**11174361.73**
Total Estimated Unduplicated Participants:	**218**
Factor D (Divide total by number of participants):	**51258.54**
Average Length of Stay on the Waiver:	345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech, Hearing, and Language Therapy Services Total:						**22147.02**
Speech/Hearing/Language	Hourly	3	93.00	79.38	**22147.02**	
Transition Assistance Services Total:						**1835.89**
Transition Assistance Services	Per item	1	1.00	1835.89	**1835.89**	
				GRAND TOTAL:		**11174361.73**
				Total Estimated Unduplicated Participants:		**218**
				Factor D (Divide total by number of participants):		**51258.54**
				Average Length of Stay on the Waiver:		345

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**192813.60**
Case Management	Hourly	210	23.00	39.92	**192813.60**	
Day Habilitation Total:						**295764.48**
Day Habilitation	Hourly	24	792.00	15.56	**295764.48**	
Residential Habilitation Total:						**3816236.94**
Consumer Directed Residential Habilitation	Hourly	6	3210.00	13.85	**266751.00**	
Residential Habilitation	Hourly	91	2486.00	15.69	**3549485.94**	
Respite Total:						**232711.08**
Consumer Directed Respite	Daily	3	14.00	227.74	**9565.08**	
Respite	Daily	49	18.00	253.00	**223146.00**	
Supported Employment Total:						**47326.15**
				GRAND TOTAL:		**11401880.43**
				Total Estimated Unduplicated Participants:		**218**
				Factor D (Divide total by number of participants):		**52302.20**
				Average Length of Stay on the Waiver:		345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consumer Directed Supported Employment	Hourly	1	454.00	34.06	15463.24	
Supported Employment	Hourly	1	907.00	35.13	31862.91	
Prescribed Drugs Total:						126336.00
Prescribed Drugs	Per Rx	48	14.00	188.00	126336.00	
Financial Management Services Total:						16720.08
Financial Management Services	Monthly	6	13.00	214.36	16720.08	
Support Consultation Total:						1484.21
Support Consultation	Monthly	1	91.00	16.31	1484.21	
Adaptive Aids and Medical Supplies Total:						23741.55
Adaptive Aids and Medical Supplies	Per Item	63	5.00	75.37	23741.55	
Assisted Living Total:						5015454.39
18 hour assisted living	Daily	8	116.00	120.12	111471.36	
24 hour assisted living	Daily	109	323.00	139.29	4903983.03	
Audiology Services Total:						2518.20
Audiology Services	Hourly	1	45.00	55.96	2518.20	
Behavioral Support Total:						65824.20
Behavioral Support	Hourly	60	13.00	84.39	65824.20	
Chore Service Total:						26306.88
Chore Service	Hourly	4	536.00	12.27	26306.88	
Dental Treatment Total:						37070.55
Dental Treatment	Per Treatment	99	1.00	374.45	37070.55	
Dietary Services Total:						1349.41
Dietary Services	Hourly	1	23.00	58.67	1349.41	
Employment Assistance Total:						47326.15
Consumer Directed Employment Assistance	Hourly	1	454.00	34.06	15463.24	

GRAND TOTAL:	11401880.43
Total Estimated Unduplicated Participants:	218
Factor D (Divide total by number of participants):	52302.20
Average Length of Stay on the Waiver:	345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Assistance	Hourly	1	907.00	35.13	31862.91	
Intervener Total:						1171856.56
Consumer Directed Intervener	Hourly	1	3084.00	18.34	56560.56	
Intervener	Hourly	63	650.00	18.01	737509.50	
Intervener I	Hourly	2	835.00	22.85	38159.50	
Intervener II	Hourly	2	835.00	27.17	45373.90	
Intervener III	Hourly	2	835.00	31.51	52621.70	
Consumer Directed Intervener I	Hourly	2	1542.00	21.79	67200.36	
Consumer Directed Intervener II	Hourly	2	1542.00	26.11	80523.24	
Consumer Directed Intervener III	Hourly	2	1542.00	30.45	93907.80	
Minor Home Modifications Total:						4811.40
Minor Home Modifications	Per Item	3	4.00	400.95	4811.40	
Nursing Total:						208896.00
Nursing	Hourly	170	30.00	40.96	208896.00	
Occupational Therapy Services Total:						25393.76
Occupational Therapy Services	Hourly	4	82.00	77.42	25393.76	
Orientation and Mobility Total:						3917.55
Orientation and Mobility	Hourly	1	91.00	43.05	3917.55	
Physical Therapy Services Total:						13558.05
Physical Therapy Services	Hourly	3	55.00	82.17	13558.05	
Speech, Hearing, and Language Therapy Services Total:						22590.63
Speech/Hearing/Language	Hourly	3	93.00	80.97	22590.63	
Transition Assistance Services Total:						1872.61
Transition Assistance Services	Per item	1	1.00	1872.61	1872.61	

GRAND TOTAL:	11401880.43
Total Estimated Unduplicated Participants:	218
Factor D (Divide total by number of participants):	52302.20
Average Length of Stay on the Waiver:	345