

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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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 a Renewal to a 1915(c) Home and Community-Based Services Waiver

### 1. Major Changes

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Describe any significant changes to the approved waiver that are being made in this renewal application:

The Medically Dependent Children Program (MDCP) waiver renewal has a few changes from the current waiver. These changes include:

- Appendix J, Cost Neutrality Demonstration, is updated for the five year renewal period.
- New waiver performance measures for health and welfare have been added to the waiver and Quality Improvement Plan has been updated and included in Appendix H per the new application structure.
- Change the name of Adjunct Support Services to Flexible Family Support Services.

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

### 1. Request Information (1 of 3)

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- A. The **State of Texas** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of  1915(c) of the Social Security Act (the Act).
- B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):  
**Medically Dependent Children Program (MDCP)**
- C. **Type of Request:**renewal

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

- 3 years  5 years

**Original Base Waiver Number:** TX.0181

**Waiver Number:** TX.0181.R05.00

**Draft ID:** TX.08.05.00

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

Regular Waiver

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

09/01/12

**Approved Effective Date:** 09/01/12

## 1. Request Information (2 of 3)

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

**Hospital**

Select applicable level of care

**Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

**Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160**

**Nursing Facility**

Select applicable level of care

**Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

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

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

**Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

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

## 1. Request Information (3 of 3)

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

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

**§1915(b)(2) (central broker)**

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

**§1915(b)(4) (selective contracting/limit number of providers)**

**A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

Specify the program:

#### H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

- This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

## 2. Brief Waiver Description

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Medically Dependent Children Program (MDCP) waiver provides supports to families and primary caregivers of individuals who wish to move from a nursing facility to the community or to remain in the community. Without MDCP waiver services, these individuals would require nursing facility or hospital care. Texas uses the MDCP waiver to provide services to Texans in the least restrictive environment possible. These environments include the individual's or a family member's home or a foster family home. MDCP strives to support inclusion of children with disabilities in a cost-effective manner through a process that does not supplant the family role and to support permanency planning for all program individuals. MDCP strives to:

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

The Department of Aging and Disability Services (DADS) does not provide MDCP waiver services to individuals who are inpatients of a nursing facility, hospital or intermediate care facility. MDCP waiver services are available in all counties within Texas.

The single State Medicaid Agency, Health and Human Services Commission (HHSC), exercises administrative discretion in the administration and supervision of the waiver, and adopts rules related to the waiver. HHSC directly performs financial eligibility determination for prospective enrollees; develops the reimbursement rate methodology and sets reimbursement rates; and conducts Medicaid fair hearings in accordance with 42 Code of Federal Regulations, Part §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 DADS as the operating agency. These functions include managing waiver enrollment against approved limits; monitoring waiver expenditures against approved levels; conducting level of care evaluation activities and authorizing level of care; reviewing service plans to ensure that waiver requirements are met; conducting utilization management and waiver service authorization functions; enrolling providers and executing the Medicaid provider agreements; conducting training and technical assistance concerning waiver requirements; managing individual's enrollment into the waiver; developing and administration of rules, policies, procedures and information; and performing quality management functions.

HHSC's Medicaid eligibility office determines financial eligibility for MDCP waiver services. A DADS case manager and regional nurse or home and community services agency nurse as applicable determine eligibility for MDCP waiver services. The DADS regional nurse or home and community services agency nurse as applicable completes an assessment to establish level of need and medical necessity for MDCP waiver services. Texas's Medicaid Management Information System contractor calculates the level of need and determines medical necessity.

The DADS case manager or the regional nurse, the individual, the parents or guardian, home and community services agency nurse as applicable and other persons requested by the individual or individual's legally authorized representative, develop a person-directed service plan that addresses the caregivers need for respite, the hours needed and the level of service needed. The process emphasizes the provision of supports and services necessary to maintain successful integration in the community. The service plan describes the medical and other services (regardless of funding source) to be furnished,

their frequency, and the provider who will furnish each waiver. Providers deliver all waiver services according to this written service plan. The service plan must have total costs that are within the applicable individual cost limit. An individual must meet financial, level of need, and service plan requirements to be eligible for MDCP waiver services.

When the service plan is developed, the individual/parent/guardian also chooses whether to self-direct the services provided through participant direction.

An individual/parent/guardian who chooses the traditional service delivery model chooses the provider for each service included in the service plan. DADS contracts with the following provider types: Consumer Directed Services Agencies, Home and Community Support Services, Out-of-Home Respite, and Transition Assistance Services. All providers, those that directly contract with DADS or are employees of DADS provider, must meet the requirements to deliver MDCP waiver services.

An individual/parent/guardian that chooses the participant-directed service delivery model chooses the provider for each service available using the participant-direction model. The individual/parent/guardian is the employer of the individual providers and the contracts with entities that provide services, such as respite care and flexible family support services provided by an attendant, a registered nurse or a licensed vocation nurse. The individual chooses a consumer directed services agency that assists the individual/parent/guardian with all aspects of being an employer and contracting with providers. This includes: assisting the individual/parent/guardian to develop a budget for participant-directed services, training the individual/parent/guardian on employer tasks, and billing DADS for services provided on behalf of the individual/parent/guardian.

### 3. Components of the Waiver Request

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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

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- A. Comparability.** The State requests a waiver of the requirements contained in  1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of  1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable**
- No**
- Yes**
- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in  1902(a)(1) of the Act (*select one*):
- No**
- Yes**

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

- Geographic Limitation.** A waiver of statewide requirements 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 statewide requirements 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

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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

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*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/MR.
- 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:  
For the renewal, the Public Notice of Intent was published in the Texas Register on April 6, 2012. Tribal notification was mailed to the tribes on March 8, 2012, allowing a comment period. There were no comments received. The comment period expired on April 7, 2012.

The State conducts meetings, webinars, and phone contacts with stakeholders related to evolving needs, barriers to participation, program policy and operations and new initiatives. Advocate groups are present along with providers in many of the meetings and webinars; however, independent communication with advocate groups and providers also occurs.

In addition to regular contacts with providers and advocates, DADS conducted a stakeholder meeting on January 3, 2012, that allowed input regarding the waiver renewal process that focused on waiver services that stakeholders

would like to see in the renewal and revision to some services that are in the currently in the waiver. Due to needs for additional funding, the State is not able to add new services at this time without legislative direction.

DADS requested that waiver stakeholders participate in a survey designed to provide feedback concerning the most effective and efficient way to establish regular communication with the greatest number of providers and stakeholders concerning the waiver. The results of this survey will be analyzed to determine the most appropriate future type and frequency of stakeholder communications.

The State also assures multiple opportunities for stakeholder and public comment in the formal rule promulgation process. Additionally, HHSC facilitates the State's Consumer Direction Workgroup, which regularly convenes to discuss and recommend improvements in the consumer directed services option offered through the State's home and community-based programs. The Promoting Independence Advisory Committee also provides a forum for public input on waiver programs.

- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

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

**Last Name:**

Johnson

**First Name:**

Betsy

**Title:**

Policy Analyst, Medicaid and CHIP

**Agency:**

Texas Health and Human Services Commission

**Address:**

11209 Metric Blvd

**Address 2:**

Mail Code H-600

**City:**

Austin

**State:**

Texas

**Zip:**

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78758

**Phone:**

(512) 491-1199

**Ext:**  TTY

**Fax:**

(512) 491-1957

**E-mail:**

betsy.johnson@hhsc.state.tx.us

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

**Last Name:**

Williamson

**First Name:**

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Dana

**Title:**

Manager, Waiver and State Plan Services

**Agency:**

Texas Department of Aging and Disability Services

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**Address:**

P.O. Box 149030

**Address 2:**

Mail Code W-579

**City:**

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Austin

**State:**

Texas

**Zip:**

78714-9030

**Phone:**

(512) 438-3385

**Ext:**  TTY

**Fax:**

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(512) 438-5768

**E-mail:**

dana.williamson@dads.state.tx.us

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## 8. Authorizing Signature

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This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are *readily* available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

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**Signature:**

Elizabeth Reekers

State Medicaid Director or Designee

**Submission Date:**

Jan 18, 2013

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

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**Last Name:**

Ghahremani

**First Name:**

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Kay

**Title:**

State Medicaid Director

**Agency:**

Texas Health and Human Services Commission

**Address:**

11209 Metric Blvd.

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Kay.Ghahremani@hhsc.state.tx.us

### **Attachment #1: Transition Plan**

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Specify the transition plan for the waiver:

The State will not terminate waiver eligibility for an individual based on the new service limits that are effective December 1, 2011, through August 31, 2013.

### **Additional Needed Information (Optional)**

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Provide additional needed information for the waiver (optional):

### **Appendix A: Waiver Administration and Operation**

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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:

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*(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:

**DADS**

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

## Appendix A: Waiver Administration and Operation

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### 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 1991 the Texas Legislature created the Texas Health and Human Services Commission (HHSC) and in 1993 it was designated the single State Medicaid Agency for the State of Texas. Most recently, in 2004, the provision of health and human services was fundamentally revised. The various health and human services agencies were reorganized into four new departments and placed under the authority of HHSC. In accordance with 42 Code of Federal Regulations §431.10(e), HHSC is the single State Medicaid Agency and retains 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 §531.0055(b), states in part:

"(b) The commission shall:

(1) Supervise the administration and operation of the Medicaid program;"

Later, in the same subsection, the Legislature gives HHSC full authority over federal funds received by the departments under its control by stating that the commission shall:

"(3) 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;"

The designation of HHSC as the single State Medicaid Agency with authority to specifically direct the workings of the Medicaid program in each agency is echoed in Texas Government Code §531.021:

"(a) The commission is the state agency designated to administer federal medical assistance funds.

(b) The commission shall:

(1) Plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program."

Through an executive directive, the State Medicaid Agency has delegated to the Department of Aging and Disability Services (DADS), an agency under HHSC's authority, responsibility for administration of waiver services, ensuring compliance with federal and state requirements and maintaining records. HHSC directly determines waiver payment amounts or rates.

The executive directive delineates the roles and responsibilities of each agency with regard to home and community-based services waivers. The executive directive also outlines the State Medicaid Agency's monitoring and oversight functions. The State Medicaid Director's Office is directly responsible for monitoring and oversight.

The executive directive identifies the following functions as DADS's responsibility to perform and HHSC's responsibility to monitor:

(1) Disseminate information concerning the waiver to potential enrollees and assist individuals in waiver enrollment.

(2) Manage waiver enrollment against approved limits and monitor waiver expenditures against approved levels by reviewing DADS interest list allocation and participant waiver enrollment count reports. Enrollment limits are approved by HHSC during the initial, renewal, and waiver amendment processes as cost neutrality calculations are adjusted;

(3) Conduct level of care evaluations.

(4) Review the service plan to ensure that waiver requirements are met.

(5) Perform prior authorization of waiver services.

(6) Conduct utilization management functions.

(7) Recruit providers.

(8) Execute the Medicaid provider agreements on behalf of HHSC, the Texas single State Medicaid Agency.

(9) Conduct training and technical assistance concerning waiver requirements. The need for training and technical assistance is identified through results of DADS's provider monitoring, technical assistance contacts, and the use of newly developed quality indicators. HHSC monitors DADS's training using the quality indicators and, when indicated, discusses, reviews, and suggests additional training topics for DADS providers.

(10) Determine waiver eligibility for individuals.

(11) Monitor waiver providers and impose sanctions for noncompliance.

Annual monitoring by HHSC relies on data from the quality measures and CMS-372 reports, includes the quality review team processes noted below, and is formally communicated to CMS and the public via the evidentiary review and annual report processes.

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

Texas's quality oversight processes provide the infrastructure for all monitoring processes, including HHSC's oversight of DADS's performance in relation to the delegated functions. The key formal mechanism for monitoring DADS's performance is the quality review team process. 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.

Many of the delegated functions are addressed in quality measures related to waiver assurances. For example, the delegated function "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 delegated functions that aren't 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 of delegated functions.

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 items are reported back 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

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

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*

The State's contracted Medicaid Management Information System functions as a Professional Review Organization, provides billing support to the State and to contracted MDCP 1915(c) waiver program providers, including:

- Processing medical necessity and level of care assessments, including the determination of medical necessity and level of care;
- Processing MDCP 1915(c) waiver program claims for payment; and
- Conducting training and technical assistance concerning MDCP 1915(c) waiver requirements.

- 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

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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

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

## Appendix A: Waiver Administration and Operation

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- 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:  
The State's contracted Medicaid Management Information System determines medical necessity for individuals in accordance with State requirements. Medical necessity is determined based on information on the assessment form completed by the DADS regional nurse or home and community services agency nurse as applicable. The medical necessity determinations are monitored on a monthly basis utilizing performance data on the number of approvals and denials of medical necessity as part of the overall management of the State's Medicaid Management Information System contractor activities.

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

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

## Appendix A: Waiver Administration and Operation

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- 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.*

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

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

**a. Methods for Discovery: Administrative Authority**

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

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Department of Aging and Disability Services - Budget: Interest List Reduction Report Summary**

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

A.a.2 Number and percent of waiver 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:

**Texas Medicaid Healthcare Partnership - Waiver Data Sheets; Department of Aging and Disability Services - Budget Reports**

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

**Data Aggregation and Analysis:**

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

**Other**  
Specify:

**Performance Measure:**

**A.a.3 Number and percent of individual service plans at or below the cost limit. N: Number of service plans at or below the waiver cost limit D: Number of service plans reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Service Authorization System**

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

**Data Aggregation and Analysis:**

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

Specify:	
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**A.a.4 Number and percent of enrollments authorized by DADS that include a valid level of care evaluation as described in the waiver application. N: Number of levels of care reviewed and authorized by DADS D: Number of levels of care reviewed**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**DADS - Community Care Case Reading System**

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

**Data Aggregation and Analysis:**

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

<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

**Performance Measure:**

**A.a.5 Number and percent of levels of care calculated by the Texas Medicaid and Healthcare Partnership within the timeframes specified in the contract. N: Number of levels of care calculated within the timeframe specified in the contract D: Number of levels of care calculated by Texas Medicaid and Healthcare Partnership**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Texas Medicaid and Healthcare Partnership - Claims Management System**

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

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**Data Aggregation and Analysis:**

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

**Performance Measure:**

**A.a.6 Number and percent of case records reviewed by DADS as part of case reading in accordance with the HHSC/DADS 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:

**DADS - Community Care Case Reading 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and	<input type="checkbox"/> Other

	<b>Ongoing</b>	Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**A.a.7 Number and percent of paid claims for services that are prior authorized by DADS N: Number of claims for waiver services that were authorized by DADS prior to service delivery D: Number of claims submitted**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Department of Aging and Disability Services - Claims Management System**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = _____

<input type="checkbox"/> <b>Other</b> Specify: <hr/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <hr/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <hr/>
	<input type="checkbox"/> <b>Other</b> Specify: <hr/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**A.a.8 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:

**Department of Aging and Disability Services - Utilization Management and Review**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = _____
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: _____

**Performance Measure:**

**A.a.9 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:

**Department of Aging and Disability Services - Contract Oversight and Support Data**

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):

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

**Performance Measure:**

**A.a.10** Number and percent of providers enrolled by DADS that had a Medicaid provider agreement executed prior to delivering services. N: Number of providers enrolled by DADS that had a Medicaid provider agreement executed prior to delivering services D: Number of providers enrolled

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Department of Aging and Disability Services - Contract Oversight and Support Data**

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

**Data Aggregation and Analysis:**

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

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Medical Care Advisory Committee quarterly meeting notes**

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**A.a.12 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):

**Record reviews, on-site**

If 'Other' is selected, specify:

**DADS Quality Reports**

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

**Data Aggregation and Analysis:**

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

**Other**  
Specify:

**Performance Measure:**

**A.a.13. 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**

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

**Data Aggregation and Analysis:**

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

	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: _____

**Performance Measure:**

**A.a.14. Number and percent of providers monitored in accordance with the schedule required by policy as determined by DADS. N: Number of providers monitored as required. 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 and Tracking System / Automated Survey Processing Environment**

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

**Data Aggregation and Analysis:**

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

<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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.

A.a.13 & A.a.14 DADS Regulatory is the entity that licenses the home and community support services agencies that provide respite and flexible family support services to MDCP individuals. DADS Regulatory staff and DADS contracts staff have ongoing communications regarding any potential actions on either licenses or contracts.

A.a.13 & A.a.14 100 percent of contracted home and community support services agencies are monitored biennially by DADS. DADS monitors a certain number of home and community support services agency providers each year. This data is reported for the year in which the provider is monitored resulting in no overlaps in reporting/monitoring.

**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 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 the 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 quarterly 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 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 on 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)**

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

**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 a group 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 waiver target group, check each of the subgroups in the selected target group 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
<input type="radio"/> <b>Aged or Disabled, or Both - General</b>					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input checked="" type="radio"/> <b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Medically Fragile	0	20	<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="radio"/> <b>Mental Retardation or Developmental Disability, or Both</b>					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Mental Retardation			<input type="checkbox"/>
<input type="radio"/> <b>Mental Illness</b>					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

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- 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:*

Transition planning begins one year before the individual's 21st birthday. The DADS case manager, staff from the receiving program and DADS registered nurse conduct a home visit to review services available through the receiving program. The receiving program intake process begins 120 days before the individual's 21st birthday.

The DADS case manager monitors the transition every three months during the year before the transition while the individual is enrolled in MDCP.

**Appendix B: Participant Access and Eligibility**

**B-2. INDIVIDUAL COST LIMIT (1 OF 2)**

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

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

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

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

Specify the percentage:

- Other**

*Specify:*

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

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

This waiver is intended to serve persons who can continue to live in their own or family home if the supports of their informal networks are augmented with basic services and supports through the waiver. Given the history of the population's service utilization, 50 percent of the institutional average as of August 31, 2010, allows flexibility for their service needs.

Texas calculates nursing facility rates by Resource Utilization Groups due to differences in consumer acuity levels. Nursing facility rates also include add-ons related to ventilator use. The combination of the Resource Utilization Groups rates and the add-ons for ventilator use totals 102 separate rates, and thus 102 different cost limits.

The individual cost limits are available in the Case Manager MDCP Handbook, which can be viewed at: <http://www.dads.state.tx.us/handbooks/cm-mdcp/>.

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

- The following dollar amount:**

Specify dollar amount: \_\_\_\_\_

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

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

Specify the formula:

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
- The following percentage that is less than 100% of the institutional average:**

Specify percent:

- Other:**

*Specify:*

The limit is 50 percent of the institutional average as of August 31, 2010.

## Appendix B: Participant Access and Eligibility

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

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

The waiver is designed to provide services and supports that are essential to allow individuals to continue to reside in their own home, foster home, or in their family home. These individuals are also anticipated to have an established natural support system. The waiver provides supports needed beyond what is provided through the state plan and the Comprehensive Care Program.

In the enrollment process, the DADS case manager, regional nurse or home and community services agency nurse as applicable, individual/parent/guardian, provider and other persons identified by the individual/parent/guardian review evaluative information and develop a person-centered plan. This plan must include a description of the current natural supports and non-waiver services that will be available to the individual if enrolled in the waiver and a description of the waiver services and supports required for the individual to continue living in his or her own home, foster home, or family's home. The individual/parent/guardian has the opportunity to review recommended services and make choices regarding the service plan. The DADS case manager or regional nurse informs the individual of the consequences of service choices, including cost implications.

The service planning team develops a service plan that includes waiver and non-waiver services and has a reasonable expectation of adequately meeting the needs of the individual in the community setting. The DADS case manager and the individual/parent/guardian must sign the service plan prior to implementation and certify that the waiver services are necessary as an alternative to institutionalization and appropriate to meet the needs of the waiver individual in the community.

The individual or the individual's legally authorized representative may request a fair hearing to dispute the denial or reduction of services for any reason, including a denial because the service plan exceeds the individual cost limit for the applicable target group, in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A. The procedures for a fair hearing are provided in Appendix F, Participant Rights.

The individual is also informed of and given the opportunity to request administrative and judicial review of a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter R.

- 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:

An individual must have a service plan at a cost within the cost limit (50 percent of institutional average as of August 31, 2010). For MDCP individuals with needs that exceed the cost limit, the State has a process to ensure their needs are met. The process includes maximizing the use of State Plan services, examining third-party resources or possible transition to another waiver or institutional services.

The individual will be informed of and given the opportunity to request a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A, if the State proposes to terminate the individual's waiver eligibility.

The individual will also be informed of and given the opportunity to request administrative and judicial review of a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter R, if the State proposes to terminate the individual's eligibility.

## Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	6901
Year 2	7175
Year 3	7450
Year 4	7724
Year 5	7999

- 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	6032
Year 2	6272
Year 3	6512
Year 4	6752
Year 5	6992

**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/Money Follows the Person Demonstration	

**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/Money Follows the Person Demonstration

**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 a community services 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 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 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 managers;
- 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	3628
Year 2	3868
Year 3	4108
Year 4 (renewal only)	4348
Year 5 (renewal only)	4588

## Appendix B: Participant Access and Eligibility

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

- d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):
- The waiver is not subject to a phase-in or a phase-out schedule.**
  - The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**
- e. Allocation of Waiver Capacity.**

*Select one:*

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

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

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

When appropriations do not support demand, all individuals who are under 21 years of age seeking waiver services are placed on an interest list. The individual must have a Texas address with the exception of individuals who are temporarily out of the state due to military assignments. DADS must maintain an up-to-date interest list and must assign an individual's placement on the interest list chronologically in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 51, Subchapter B, §51.201. If an individual seeking entrance into MDCP meets the criteria for the reserved capacity group they bypass the interest list as long as there are reserved waiver capacity slots available.

Periodically, DADS prospectively forecasts whether MDCP slots will become available in future months. If DADS

forecasts that MDCP slots will be available, DADS also estimates the number of individuals that DADS will be able to enroll into MDCP by taking into account currently vacant slots as well as future slots anticipated to become vacant through attrition. Based upon the estimated number of slots that will become vacant as well as the historical  take up  rate (the percentage of individuals released from the MDCP interest list who ultimately are successfully enrolled in the program), DADS authorizes a certain number of names to be  released  from the interest list. DADS then contacts these individuals who, based on the position of the individual's name on the interest list, might be enrolled into MDCP. If the individual wants to apply for MDCP, DADS begins the MDCP eligibility determination process at least 30 days before an MDCP slot is forecast to be available. If an individual is no longer interested in applying for MDCP or is determined ineligible for MDCP, DADS removes the name of the individual from the interest list. An individual can be receiving other HCBS waiver services and be on the MDCP interest list.

If an individual is denied waiver enrollment based on diagnosis, medical necessity or other functional eligibility requirements, a DADS representative will notify 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 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 interest list request date.

## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a (*select one*):

- §1634 State  
 SSI Criteria State  
 209(b) State

2. **Miller Trust State.**

Indicate whether the State is a Miller Trust State (*select one*):

- No  
 Yes

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

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

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

*Select one:*

- 100% of the Federal poverty level (FPL)

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

Specify percentage:

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

Specify:

All other mandatory and optional AFDC-related groups under the State Plan are included.

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***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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:

Select one:

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

Specify percentage:

- A dollar amount which is lower than 300%.

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- Medically needy without 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 4)

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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

- 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 (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 4)

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

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

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

- The following standard included under the State plan**

Select one:

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

(select one):

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

Specify the percentage: \_\_\_\_\_

- A dollar amount which is less than 300%.

Specify dollar amount: \_\_\_\_\_

- A percentage of the Federal poverty level

Specify percentage: \_\_\_\_\_

- Other standard included under the State Plan**

Specify:

- The following dollar amount**

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

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

Specify:

- Other**

Specify:

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

- Not Applicable (see instructions)
- SSI standard

- Optional State supplement standard**
- Medically needy income standard**
- The following dollar amount:**

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

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

*Specify:*

---

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

---

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

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

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

*Specify:*

- Other**

*Specify:*

---

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

---

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

Select one:

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

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (3 of 4)

#### 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 4)

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

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

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

## Appendix B: Participant Access and Eligibility

### B-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:*

The level of care assessments are performed by registered nurses who may be employed by the operating agency specified in Appendix A or a home and community supports agency contracted with the operating agency. The State's contracted Medicaid Management Information System evaluates these assessments and calculates the medical necessity and level of care in accordance with state-established criteria.

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

The educational and professional qualifications of persons performing initial evaluations of level of care for waiver individuals are: Registered nurse licensed by the State, with experience in pediatrics, and who has completed a level of care training within the last two years.

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

The medical necessity and level of care assessment form is used to complete level of care and medical necessity assessments.

For individuals to qualify for nursing facility care, their medical conditions and health care needs are, at a minimum, such that they require institutional care under the supervision of a physician. Individuals must meet the level of care and medical necessity criteria for nursing facility admission as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 19, Subchapter Y and must have a medical condition of sufficient seriousness that the individual's needs exceed the routine care which may be given by an untrained person and require nurse supervision, assessment, planning, and intervention on a regular basis. Factors assessed include:

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

The level of care is determined by combining an activity of daily living score with assessments of the medical condition, rehabilitation, nursing care, and confusion or behavioral problems. The activity of daily living score is calculated by combining scores for transferring, eating, and toileting. A low activity of daily living score indicates greater independence. Texas Medicaid and Healthcare Partnership systems automatically review specific criteria on the assessments. If the criteria are appropriately met, the assessment is automatically approved. If not, the assessment will then be sent to a nurse for manual review. There is not a particular score that indicates that an individual meets the nursing facility level of care.

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

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

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

- 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 registered nurse completes the individual's medical necessity and level of care assessment. This assessment is submitted to the State's contracted Medicaid Management Information System, where registered nurses and physicians review the assessment, verify the level of care and calculate the Resource Utilization Group in accordance with State-established criteria. The process is the same for level of care initial evaluations and reevaluations.

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

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):
- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
  - The qualifications are different.**  
*Specify the qualifications:*

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

Services are authorized for a 12-month period. The service plan is prorated for the annual period in which the individual turns 21. The DADS case manager and the registered nurse, who may be employed by the operating agency or a home and community supports agency contracted with the operating agency, must complete the reevaluation in a timely manner in order to ensure continued payment. The annual assessment is a key activity of case management. DADS contract staff perform monitoring visits, which include reviews to determine if annual assessments are completed as required and in a timely manner. DADS case managers ensure payment is not provided if required reevaluations are not completed.

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

The State's contracted Medicaid Management Information System and DADS maintain records of level of care and medical necessity evaluations and reevaluations in accordance with State record retention requirements.

## 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**

**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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

**Performance Measure:**

**B.a.1 Number and percent of individuals for whom medical necessity/level of care is determined prior to enrollment. N: Number of new enrollees whose level of care was completed prior to receipt of first service. D: Number of new enrollees.**

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**DADS - Community Care Case Reading System**

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

	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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 The number and percent of individuals for whom medical necessity/level of care is reassessed annually or as specified in the approved waiver. N: number of enrolled individuals whose level of care is re-evaluated annually D: number of enrolled individuals**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DADS - Community Care Case Reading System**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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 The number and percent of individuals' level of care determinations that were completed as required by the State. N: Number of new and enrolled individuals' initial and annual level of care determinations that were completed as required by the State D: Number of new and enrolled individuals**

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**DADS - Community Care Case Reading System**

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

**Data Aggregation and Analysis:**

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

Manual processes: While the State's contracted Medicaid Management Information System processes assure that documentation supports that the individual meets the nursing facility level of care, each medical necessity and level of care is reviewed by DADS prior to authorizing services. DADS confirms there is a valid medical necessity and level of care before processing an authorization for services in the Service Authorization System.

Medicaid Management Information System: The Department of Aging and Disability Services monitors the State's contracted Medicaid Management Information System. The State contractor produces a report and delivers it to the DADS on a monthly basis. This report provides metrics for medical necessity determinations made by the contractor based on the medical necessity and level of care assessment. These metrics include total number of medical necessity and level of care assessments, number of medical necessity level of care assessments denied medical necessity, and the timeliness of medical necessity level of care assessment determinations.

DADS reviews this report for any errors and for trending in case there are any problems based on the metrics. If there are any other reports of problems with medical necessity determinations from either providers or individuals, these problems are brought to the attention of the Texas Medicaid and Healthcare Partnership for timely and accurate resolution. If there are any performance issues with the Texas Medicaid and Healthcare Partnership for medical necessity determinations, those problems are addressed through the Medicaid Contract Administration Tracking System.

Utilization Review: The State's utilization review process also assesses medical necessity and level of care and appropriateness of services. A statistically significant number of active cases are randomly selected for utilization review, and other cases are also referred prior to authorization based on established referral criteria. Each utilization review of an individual's case, whether randomly selected or referred prior to authorization, includes a review of the medical necessity and level of care on file and a comparison to the individual's current needs and service plan. In addition, specific medical necessity and level of care assessments are randomly selected for utilization review.

**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.

**Utilization Review:** The utilization review process identifies medical necessity/level of care determinations that need to be reviewed. The process includes entering data obtained by the utilization review registered nurse into the State's contracted Medicaid Management Information System portal. The utilization review assessment overrides the DADS regional nurse's or home and community support services agency nurse's assessment. Reports will be generated to show the number of assessments that received a utilization review, and of those, the number of assessments changed. Once data is available, the State will track and trend these reviews for overall program improvement.

**Case Reading:** The Community Care Case Reading system is an automated system specifically designed to capture case reading data and generate reports. DADS state office staff is required to review a random sample on a monthly basis and enter the results of each case reviewed into the Community Care Case Reading system. The data entered in the Community Care Case Reading system is monitored by state office staff to ensure timely completion of monthly case reading samples by each region. During the case reading process, the case reader reviews the case record to ensure the medical necessity and level of care is approved and the services authorized are within the allowable cost limit associated with the approved medical necessity and level of care.

Errors identified through case reading are also entered into the Community Care Case Reading system and an error correction report is generated monthly indicating outstanding errors needing to be corrected. State office staff monitors the Community Care Case Reading system to ensure timely error corrections are made. Error trends are identified through the Community Care Case Reading system, and are addressed through immediate feedback, technical assistance and policy development.

Three times per year, DADS state office staff pulls a statistically valid random sub-sample of cases that have been reviewed in the regions and a validation session is held. During the validation session, designated regional staff attends the validation session and reviews the sub-sample to ensure policy is being followed in each region. A level of agreement for each region in each standard is then calculated by the regional and validation findings. If a region's level of agreement is below 95 percent in any standard, the regional case reading finding for that standard is discarded and the validation finding is used instead. This validation finding then becomes the official finding for that standard.

Each standard has a corresponding tolerance level. Any region scoring below the allowable tolerance level in any standard for two consecutive validation sessions is placed on corrective action for that standard. The region is required to develop a program improvement plan that is reviewed and monitored by state office.

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

**ii. Remediation Data Aggregation**

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

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

**Other**
Specify: **c. Timelines**

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

 **No**
 **Yes**

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

B.a.1 and B.b.1- A request is pending with DADS Information Technology to obtain the appropriate data. Expected completion date is March 1, 2013. Data will be available September 1, 2013. If changes are needed to these performance measures, at that time the State will submit an amendment.

## Appendix B: Participant Access and Eligibility

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### B-7: Freedom of Choice

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

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

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

The DADS case manager informs each individual of any alternatives available, including the choice of institutional care versus home and community-based waiver services at the time of the initial assessment and reassessment, and when there is a provider change.

The service plan has a section entitled Freedom of Choice. The individual/parent/guardian signs this section to indicate he or she freely chooses waiver services over institutional care. The DADS case manager also addresses living arrangements and choice of providers as well as available third party resources during the assessment. All individuals have the right to appeal any decision they believe is adverse to their freedom of choice.

The DADS case manager and the home and community support services agency are required to retain copies of the service plan with the freedom of choice section in the case record. The service plan contains the individual's acknowledgement and signature related to freedom of choice.

- 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 DADS case manager retains a copy of the the service plan with the freedom of choice section according to the State's records retention requirements.

## Appendix B: Participant Access and Eligibility

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### 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 Spanish translations of written materials for state office and the regions. This unit is also responsible for: reviewing and evaluating Spanish translations that were prepared elsewhere; proofreading translated copy to ensure accuracy; translating individual correspondence sent to state office; providing voice talent for audio and video productions; and 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	Respite		
Supports for Participant Direction	Financial Management Services		
Other Service	Adaptive Aids		
Other Service	Flexible Family Support Services		
Other Service	Minor Home Modifications		
Other Service	Transition Assistance Services		

## Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Respite

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

Respite

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

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

Individual's home or place of residence;

Foster home (as defined in the Human Resources Code, §42.002);

Medicaid certified hospital;

Medicaid certified nursing facility;

Specialty Care Facilities (an institution or establishment that provides a continuum of nursing or medical care or

services primarily to persons with acquired immune deficiency syndrome or other terminal illnesses. The term includes a special residential care facility.);  
 Host Families residence (must be licensed as a foster home by the Texas Department of Family and Protective Services or verified by a child-placing agency that is licensed by the Texas Department of Family and Protective Services);  
 Accredited camps; and  
 Licensed child care settings.

Federal financial participation is claimed for room and board for respite services delivered in the following settings: Medicaid certified hospitals; Medicaid certified nursing facilities; Specialty Care Facilities; accredited camps; host families; and licensed child care settings.

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

Respite may not be provided in a setting in which identical services are already being provided. In general, an individual may receive a maximum of 2,096 hours of respite services per service plan year of which 144 hours (6 days) may be facility-based respite. Exceptions to the service limit will be granted on an individual basis if the need for respite is greater than 2,096 hours or 6 days of facility-based respite. DADS will grant an exception to the 2,096 hours or 6 days service limits if there is evidence indicating that exceeding the service limit is necessary to protect the individual's health and welfare. If an exception is granted facility based respite may not exceed 29 days per waiver plan year and is subject to the waiver cost limit. If the need for respite is greater than 29 days, DADS will grant an exception on an individual basis if the need for respite is necessary to protect the individual's health and welfare. Request for exceptions are submitted to the DADS case manager, who can consult with the DADS regional nurse as needed.

If the State denies the request for additional respite, the State offers the individual a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A. The individual is also informed of and given the opportunity to request administrative and judicial review of a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter R.

**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	Child Day Care Facilities (Out of Home Respite)
Individual	Host Family
Individual	Participant Employer Direct Service Provider
Agency	Home and Community Support Services Agency
Agency	Special Care Facilities (Out of Home Respite)
Agency	Hospital (Out of Home Respite)
Agency	Nursing Facility (Out of Home Respite)
Agency	Camp (Out of Home Respite)

## Appendix C: Participant Services

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

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

**Provider Category:**

Agency

**Provider Type:**

Child Day Care Facilities (Out of Home Respite)

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

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

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

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

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

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

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

DADS verifies provider qualifications for Day Care Facilities.

**Frequency of Verification:**

Every two years.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**


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


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**Provider Category:**

Individual

**Provider Type:**

Host Family

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

Department of Family and Protective Services Title 40, Texas Administrative Code, Part 19, Chapter 749

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

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

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

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

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

Department of Family and Protective Services.

**Frequency of Verification:**

Initially and annually.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Individual

**Provider Type:**

Participant Employer Direct Service Provider

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

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

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

The provider of the respite service component must be at least 18 years of age. The provider must have a high school diploma or certificate of high school equivalency (GED credentials) and competence to perform job tasks and the ability to provide the required services as needed by the individual to be served. The provider cannot be the individual's legally authorized representative or the spouse of the legally authorized representative.

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

The participant employer or legally authorized representative and consumer directed services agency.

DADS

**Frequency of Verification:**

The participant employer or legally authorized representative and the consumer directed services agency verify that each potential service provider meets the required qualifications prior to hiring.

DADS monitors the consumer directed services agencies at a minimum every three years.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Home and Community Support Services Agency

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

Home and Community Based Support Services Agency - DADS Title 40 of the Texas Administrative Code, Part 1, Chapter 97

**Certificate (specify):**

**Other Standard (specify):**

Home and community support services agencies must also comply with Title 40 of the Texas Administrative Code, Part 1, Chapter 48, Subchapter J.

The home and community support services agency must employ a respite attendant who must meet the following requirements:

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

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

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

DADS verifies provider qualifications for home and community support services agencies.

**Frequency of Verification:**

DADS verifies provider qualifications prior to awarding a provider agreement.

DADS Community Services Contracts staff is responsible for conducting monitoring reviews according to Title 40 of the Texas Administrative Code, Part 1, Chapter 48, Subchapter J and Title 40 of the Texas Administrative Code, Chapter 49 every two years. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

Contracts staff conduct a follow up review for contractors with an overall compliance score less than 90 percent. 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 home and community support services agencies and is responsible for ensuring that providers meet licensing qualifications. Home and community support services agencies are surveyed for compliance during the initial application process and at least every two years thereafter according to Title 40 of the Texas Administrative Code Part 1, Chapter 97. Home and community support services agencies are inspected to ensure compliance with licensing requirements. The inspection includes observation of the care of a sample of individuals. Licenses are valid for two years. Complaint investigations involving alleged licensing violations are

conducted according to the priority of the allegations.

DADS has 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:**

Special Care Facilities (Out of Home Respite)

**Provider Qualifications**

**License (specify):**

Department of State Health Services Title 25 of the Texas Administrative Code, Part 1, Chapter 125.

**Certificate (specify):**

**Other Standard (specify):**

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department of State Health Services licenses special care facilities. DADS verifies providers are licensed upon initial contracting.

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Hospital (Out of Home Respite)

**Provider Qualifications**

**License (specify):**

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

**Certificate (specify):**

**Other Standard (specify):**

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

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

#### **Verification of Provider Qualifications**

##### **Entity Responsible for Verification:**

Department of State Health Services licenses hospitals. DADS verifies providers are licensed upon initial contracting.

##### **Frequency of Verification:**

Department of State Health Services is responsible for ensuring compliance with licensure. The Department of State Health Services surveys one time in the first two years of the license; thereafter, based upon complaints. For accredited hospitals due to Medicare, the State does a full survey within a month if the hospital gives up or loses its accreditation.

If they are accredited by the:

Joint Commission, the Joint Commission surveys once every 36 months – 39 months.

Det Norske Veritas Organization, the Det Norske Veritas Organization surveys annually.

## **Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Respite**

#### **Provider Category:**

Agency

#### **Provider Type:**

Nursing Facility (Out of Home Respite)

#### **Provider Qualifications**

##### **License (specify):**

DADS Title 40 of the Texas Administrative Code, Part 1, Chapter 19

##### **Certificate (specify):**

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

The nursing facility respite provider must employ staff who must:

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

#### **Verification of Provider Qualifications**

##### **Entity Responsible for Verification:**

DADS licenses nursing facilities.

**Frequency of Verification:**

DADS Regulatory Services licenses nursing facilities and is responsible for ensuring that facilities meet licensing qualifications. Nursing facilities are surveyed during their first year of operation and approximately 9-15 months after the licensure according to Title 40 of the Texas Administrative Code, Part 1, Chapter 19. Nursing facilities are inspected to ensure compliance with licensing requirements. The inspection includes observation of the care of a sample of individuals

## Appendix C: Participant Services

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

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**Service Type: Statutory Service**

**Service Name: Respite**

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**Provider Category:**

Agency

**Provider Type:**

Camp (Out of Home Respite)

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

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

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

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

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

These camps are accredited by the American Camping Association.

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

Department of State Health Services licenses camps. DADS verifies providers are licensed upon initial contracting.

**Frequency of Verification:**

Department of State Health Services is responsible for ensuring compliance with licensure. This is done annually or more often if there is a complaint.

## Appendix C: Participant Services

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

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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):**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Financial management services provides assistance to individuals with managing funds associated with the services elected for self-direction. The service includes initial orientation and ongoing training related to responsibilities of being an employer and adhering to legal requirements for employers. The financial management services provider, referred to as the consumer directed services agency, also:

Serves as the participant's employer-agent, which is the Internal Revenue Service's (IRS) designation of the entity responsible for IRS related responsibilities on behalf of the participant. As the employer-agent the CDSA also files required forms and reports to the Texas Workforce Commission.

Provides assistance in the development, monitoring and revision of the individual's budget;

Provides information about recruiting, hiring and firing staff including identifying the need for special skills and determining staff duties and schedule;

Provides guidance on supervision and evaluation of staff performance;

Provides assistance in determining staff wages and benefits subject to State limits, assistance in hiring by verifying employee's citizenship status and qualifications, and conducting required criminal background and registry checks;

Verifies and maintains documentation of employee qualifications, including citizenship status, and documentation of services delivered;

Collects timesheets, processes timesheets of employees, processes payroll and payables and makes withholdings for, and payment of, applicable federal, state and local employment-related taxes; and

Tracks disbursement of funds and provides quarterly written reports to the individual of all expenditures and the status of the individual's CDS budget. Maintains a separate account for each participant's budget.

The State allows a participant to select a relative or legal guardian, other than a legally responsible individual, to be their provider for this service if the relative or legal guardian meets the requirements for this type of provider.

**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	Consumer Directed Services Agency

## Appendix C: Participant Services

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

#### Service Type: Supports for Participant Direction

**Service Name: Financial Management Services**

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**Provider Category:**

Agency

**Provider Type:**

Consumer Directed Services Agency

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

Private entities furnish financial management services. These entities, called consumer directed services agencies, are procured through an open enrollment process and are required to hold a Medicaid provider agreement with the State. Through a delegation arrangement, DADS executes a contract with the required elements of Medicaid provider agreement on behalf of HHSC.

Prior to contracting with DADS to provide financial management services, a consumer directed service agency must comply with the requirements for delivery of financial management services, including attending a DADS mandatory 3-day training session. Topics covered in the training session include: contracting requirements and procedures; consumer directed service agency responsibilities; consumer/employer responsibilities; DADS case manager/service coordinators 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 70-6, 1970-1 C.B. 420 and an explanation of fiscal employer agent based on Section 3504 of the IRS code and state tax (unemployment) requirements as a Vendor Fiscal/Employer Agent. The training also covers IRS Forms SS-4 and 2678. The rules for the consumer directed services option, located at Title 40 of the Texas Administrative Code, Part 1, Chapter 41, require consumer directed services agencies to act as vendor fiscal/employer agents along with describing responsibilities such as the revocation of IRS Form 2678 if the individual terminates the consumer directed services option or transfers to another consumer directed service agency.

The consumer directed 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 representative.

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

DADS

**Frequency of Verification:**

DADS monitors the consumer directed services agencies at a minimum every three years. Consumer directed services agencies are monitored more frequently if the need is indicated or if there is a complaint filed against the consumer directed services agency. A key part of that monitoring is to ensure that the consumer directed services agency has verified that each potential employee meets the required qualifications prior to being hired. As a result of the review, DADS will recoup the financial management services payment and any payments for providers who were unqualified at the time they provided 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 consumer directed services agency provider, including consumer hold, vendor hold and/or termination.

**Appendix C: Participant Services**

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**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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Adaptive aids are devices necessary to treat, rehabilitate, prevent or compensate for conditions resulting in disability or loss of function. Adaptive aids enable people to perform the activities of daily living or control the environment in which they live.

Adaptive aids are available through this waiver program only after benefits available through Medicare; Medicaid; Early Periodic Screening, Diagnostic or Treatment program or other third party resources have been exhausted.

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

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

If the State denies the request for adaptive aids, the State offers the individual a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A. The individual is also informed of and given the opportunity to request administrative and judicial review of a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter R.

**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	Durable Medical Equipment Supplier

## Appendix C: Participant Services

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

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**Service Type: Other Service**  
**Service Name: Adaptive Aids**

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**Provider Category:**

Agency

**Provider Type:**

Durable Medical Equipment Supplier

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

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

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

DADS

**Frequency of Verification:**

Upon enrollment.

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## Appendix C: Participant Services

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### 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:**

Flexible Family Support Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

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

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

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

Flexible family support services may be used only when the primary caregiver is working, attending job training, or attending school. Flexible family support services may not be used in place of child care that is paid for by the primary caregiver. An individual may receive a maximum of 1,875 hours of flexible family support services per service plan year. Exceptions to the service limit will be granted on an individual basis if the need for flexible family support services is greater than 1,875 hours. DADS will grant an exception to the 1,875 hours if there is evidence indicating that exceeding the service limit is necessary to protect the individual's health and welfare. If an exception is granted, it is subject to the individual cost limit for the waiver. Request for exceptions are submitted to the DADS case manager, who can consult with the DADS regional nurse as needed.

If the State denies the request for additional flexible family supports, the State offers the individual a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A. The individual is also informed of and given the opportunity to request administrative and judicial review of a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter R.

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Participant Employer Direct Service Provider
Agency	Home and Community Support Services Agency

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Flexible Family Support Services**

**Provider Category:**

Individual

**Provider Type:**

Participant Employer Direct Service Provider

**Provider Qualifications**

**License** (specify):

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

**Certificate** (specify):

**Other Standard** (specify):

The provider of the flexible family support service component must be at least 18 years of age and have a high school diploma or certificate of high school equivalency (GED credentials). The provider must have experience and competence to perform job tasks. The provider cannot be the individual's legally authorized representative or the spouse of the legally authorized representative.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The participant employer or the legally authorized representative and consumer directed services agency.

DADS

**Frequency of Verification:**

The participant employer or legally authorized representative and the consumer directed services agency verify that each potential service provider meets the required qualifications prior to hiring.

DADS monitors the consumer directed services agencies at a minimum every three years.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Flexible Family Support Services**

**Provider Category:**

Agency

**Provider Type:**

Home and Community Support Services Agency

**Provider Qualifications**

**License (specify):**

Home and Community Support Services Agency - DADS Title 40 of the Texas Administrative Code, Part 1, Chapter 97

**Certificate (specify):**

**Other Standard (specify):**

Home and community support services agencies must also comply with Title 40 of the Texas Administrative Code, Part 1, Chapter 48, Subchapter J.

The home and community support services agency must employ an attendant who must meet the following requirements:

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

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

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

DADS - Home and Community Support Services Agency

**Frequency of Verification:**

DADS verifies provider qualifications prior to awarding a provider agreement.

DADS Community Services Contracts staff is responsible for conducting monitoring reviews according to Title 40 of the Texas Administrative Code, Part 1, Chapter 48, Subchapter J and Title 40 of the Texas Administrative Code, Chapter 49 every two years. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

Contract staff conduct a follow up review for contractors with an overall compliance score less than 90 percent. Contract 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 home and community support services agencies and is responsible for ensuring that providers meet licensing qualifications. Home and community support services agencies are surveyed for compliance during the initial application process and at least every two years thereafter according to Title 40 of the Texas Administrative Code Part 1, Chapter 97. Home and community support services agencies are inspected to ensure compliance with licensing requirements. The inspection includes observation of the care of a sample of individuals. Licenses are valid for two years. Complaint investigations involving alleged licensing violations are conducted according to the priority of the allegations.

DADS has 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:**

Minor Home Modifications

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

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

All minor home modifications must be authorized by DADS staff and must meet the criteria as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 51.

Covered modifications are limited to:

The purchase and installation of permanent and portable ramps not covered by other sources;

The widening of doorways;  
 Modifications of bathroom facilities; and  
 Modifications related to the approved installation or modification of ramps, doorways, or bathroom facilities.  
 All services shall be provided in accordance with applicable State and local building codes.

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

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

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Contractor

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Minor Home Modifications

**Provider Category:**

Individual

**Provider Type:**

Contractor

**Provider Qualifications**

**License** (specify):

Licensed where applicable.

**Certificate** (specify):

Certified where applicable.

**Other Standard** (specify):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DADS

**Frequency of Verification:**

At the time of enrollment.

## 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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

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

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 individuals health and welfare such as pest eradication and one-time cleaning prior to occupancy; and
- Activities to assess need, arrange for, and procure needed resources (limited to up to 180 consecutive days prior to discharge from the nursing facility).

Transition assistance services funding is authorized for expenses that are:

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

To be eligible to receive transition assistance services the individual must:

- Be a resident of a Texas nursing facility;
- Be Medicaid eligible; and
- Be determined eligible for waiver services

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

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

Room and board are not allowable expenses.

Transition assistance services does not include:

- monthly rental or mortgage expenses;
- food;
- regular utility charges; or
- household appliances or items that are intended for purely diversional or recreational purposes.

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

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

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transition Assistance Services provider

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Transition Assistance Services**

**Provider Category:**

Agency

**Provider Type:**

Transition Assistance Services provider

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DADS

**Frequency of Verification:**

DADS Community Services Contracts staff is responsible for conducting monitoring reviews every two years. Contract 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 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 contract and licenses 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:

- As a waiver service defined in Appendix C-3.** Do not complete item C-1-c.

- As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- As an administrative activity.** *Complete item C-1-c.*
- c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

DADS  case managers will conduct the case management functions.

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

- a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- No. Criminal history and/or background investigations are not required.**
- Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Providers, consumer directed services agencies and participant employers must comply with the Texas Health and Safety Code, Chapter 250, by taking the following actions regarding individuals, employees, and contractors. Consumer directed services agencies must also comply with Title 40 of the Texas Administrative Code, Part 1, Chapter 41, Subchapter C:

(A) Obtain Texas criminal history record information from the Texas Department of Public Safety that relates to an unlicensed applicant, employee, volunteer or contractor whose duties would or do involve direct contact with an individual, and;

(B) Refrain from employing or contracting with, or immediately discharge, a person who has been convicted of an offense that bars employment under Texas Health and Safety Code §250.006, or an offense that the provider or participant employer determines is a contraindication to the person's employment or contract to provide services to the individual.

Providers, participant employers and consumer directed service agencies are also required to perform criminal history checks on contractors.

Providers and individuals who participate in consumer directed services (participant employer) 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 a designated representative, an employee, or a contractor.

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.

Providers are required to maintain documentation of the criminal history checks performed. Providers, participant employers and consumer directed services agencies must keep a copy of the criminal history check for each designated representative, employer and contractor.

Each individual who chooses self-direction must choose a consumer directed services agency that provides guidance and assistance to the individual with employer-related tasks. The consumer directed services agency is required to have verification of the criminal history check prior to finalizing the hiring process on behalf of the participant employer. During on-site reviews of providers and consumer directed services agencies, DADS

reviews for completion of criminal history checks as required.

Providers must screen all employees and contractors for exclusion prior to hiring or contracting, and monthly on an ongoing basis, by searching both the state and federal lists of excluded individuals and entities. If any exclusion is found they must immediately be reported to DADS.

For volunteers, the home and community support services providers must comply with Title 40 of the Texas Administrative Code, Part 1, Chapter 97, Subchapter C.

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

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

- No. The State does not conduct abuse registry screening.**
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

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

Providers, consumer directed services agencies and participant employers must comply with Texas Health and Safety Code, Chapters 250 and 253, by taking the following action regarding applicants, employees, and contractors:

(A) Search the Nurse Aide Registry maintained by DADS in accordance with Texas Health and Safety Code, Chapter 250, and refrain from employing or contracting with, or immediately discharge, a person who is designated in the registry as having abused, neglected, or mistreated an individual of a facility or has misappropriated an individual's property; and

(B) Search the Employee Misconduct Registry maintained by DADS in accordance with Texas Health and Safety Code Chapter 253, and refrain from employing or contracting with or immediately discharge, a person whose 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, participant employers and consumer directed 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.

Providers, consumer directed services agencies and participant 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 consumer directed services agency that provides guidance and assistance to the individual with employer-related tasks. The consumer directed services agency is required to have verification of the registry checks prior to hiring on behalf of the individual. During on-site reviews of program providers and consumer directed services agencies, DADS monitors for completion of required registry checks.

For volunteers, the home and community support services providers must comply with Title 40 of the Texas Administrative Code, Part 1, Chapter 97, Subchapter C.

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.

## 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	
Host Family	

- 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.

#### Host Family

Respite is provided in a traditional family home environment that must meet foster home qualifications for licensure. The individuals live and interact as a family group. Individuals that live with a host family have rights including the following:

- Have personal possessions at home and to get additional things within reasonable limits, as planned for and discussed by the individual's caregiver and caseworker, and based on caregiver's ability;
- Have personal space in my bedroom to store my clothes and belongings;
- Have healthy foods in healthy portions proper for my age and activity level;
- Visit and have regular contact with my family, including brothers and sisters;
- Actively participate in creating my plan for services;
- Have contact with persons outside the foster care system. These visitors can be, but are not limited to, teachers, church members, mentors, and friends; and
- Have privacy to keep a personal journal, to send and receive unopened mail, and to make and receive private phone calls unless an appropriate professional or a court says that restrictions are necessary for the individual's best interests.

The host family must ensure that:

- The home is safe for children, kept clean, and in good repair;
- Equipment and furniture are safe for children, kept clean, and in good repair;
- Exits in living areas are not blocked by furniture;
- The outdoor areas are safe for children, kept clean, and in good repair;
- Outdoor areas are well drained;
- Windows and doors used for ventilation are screened;
- Flammable or poisonous substances are stored out of the reach of children unless caregivers have evaluated a child as capable and likely to use such items responsibly; and
- The home is free of rodents and insects.

#### Bedrooms

A bedroom must have at least 40 square feet of space for each occupant and no more than four occupants per bedroom are permitted, even if the square footage of the room would accommodate more than four occupants. The four occupants restriction does not apply to children receiving treatment services for primary medical needs.

Other bedroom requirements:

- Single occupant bedrooms must have at least 80 square feet of floor space.

- The floor space requirement must not include closets or other alcoves.
- Floor space must be space that children can use for daily activities.
- Only a room that provides adequate opportunities for rest and privacy may be used as a bedroom.
- Bedrooms used by foster children must have at least one source of natural lighting.
- Foster children or any other household members may not use any of the following as a bedroom:
  - A room commonly used for other purposes, including dining rooms, living rooms, hallways, or porches;
  - A passageway to other rooms; or
  - A room that does not have doors for privacy.
  - A foster child may use a detached structure as a bedroom if:
    - o The child is 16 years old or older;
    - o The service planning team approves; and
    - o The detached structure is included in required fire and health inspections for the foster home.
- A foster child may use a basement as a bedroom if there is a second fire escape route from the basement.

**Bathroom requirements:**

Each child must have accessible storage space for his clothing and personal possessions.

The home must have one lavatory, one tub or shower, and one toilet for every eight household members. A foster home verified before January 1, 2007, is exempt from this requirement until it is no longer verified by the agency under which it is currently verified, or it makes structural changes to the home by adding additional bathrooms.

All lavatories, tubs, and showers must have hot and cold running water.

For homes that care for primary medical needs children, the child's bedroom and the child's bathroom must be located on the same floor. A foster home verified before January 1, 2007, is exempt from this requirement until it is no longer verified by the agency.

Bathrooms must allow for privacy.

Children must have indoor areas for their use. There must be at least 40 square feet for each child. This does not include bedrooms, kitchens, bathrooms, utility rooms, unfinished attics, or hallways.

## **Appendix C: Participant Services**

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### **C-2: Facility Specifications**

**Facility Type:**

Host Family

**Waiver Service(s) Provided in Facility:**

<b>Waiver Service</b>	<b>Provided in Facility</b>
<b>Adaptive Aids</b>	<input type="checkbox"/>
<b>Flexible Family Support Services</b>	<input type="checkbox"/>
<b>Financial Management Services</b>	<input type="checkbox"/>
<b>Transition Assistance Services</b>	<input type="checkbox"/>
<b>Respite</b>	<input checked="" type="checkbox"/>
<b>Minor Home Modifications</b>	<input type="checkbox"/>

**Facility Capacity Limit:**

No more than six children in the home including the foster families own children or children for whom they provide day care.

**Scope of Facility Standards.** 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	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

**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.*

- 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.

The State allows an individual to select a relative or legal guardian, other than a spouse, to be their provider for adaptive aids, flexible family support services, financial management services, minor home modifications, and respite. The relative or legal guardian must meet the requirements to provide waiver services and cannot be the parent or legal guardian of an individual who is under age 18.

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

The State ensures waiver services provided by a relative are in the best interest of the individual through the development of the service plan and the requirement for DADS to approve the service plan.

- Other policy.**

Specify:

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

DADS maintains open enrollment for MDCP providers. The contracting process normally takes 45 days. The following processes are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 Code of Federal Regulations §431.51.

Entities interested in contracting to provide MDCP services must apply to be a provider as described in 40 Texas Administrative Code Part 1, Chapter 49, subchapter B, relating to requirements for contracting for community care services.

DADS Community Services Contracts unit provides information on how to become a MDCP provider. The DADS webpage also has information on contracting with DADS to provide any service. Information on all requirements is available.

## 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**

**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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 # and % of newly enrolled licensed &/or certified providers that initially met required licensure, certification, & other standards prior to furnishing waiver services. N:# of newly enrolled licensed &/or certified providers that initially met required licensure, certification, & other standards prior to furnishing waiver services D:# of newly enrolled licensed &/or certified providers**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Health and Human Services Contract Administration and Tracking System**

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

	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**C.a.2 Number and percent of monitored licensed and/or certified providers that met required licensure, certification, and other standards. N: Number of monitored licensed and/or certified providers that met required licensure, certification, and other standards. D: Number of licensed and/or certified providers monitored.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Health and Human Services Contract Administration and Tracking System**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>

<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = _____
<input type="checkbox"/> <b>Other</b> Specify: _____	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input checked="" type="checkbox"/> <b>Other</b> Specify: biennially	

**Data Aggregation and Analysis:**

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

- b. **Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

appropriate.

**Performance Measure:**

**C.b.1 Number and percent of newly enrolled non-licensed/non-certified providers that initially met waiver requirements prior to furnishing waiver services. N: Number of newly enrolled non-licensed/non-certified providers that initially met waiver requirements prior to furnishing waiver services. D: Number of newly enrolled non-licensed/non-certified providers.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Health and Humans Services Contract Administration and Tracking System**

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

**Data Aggregation and Analysis:**

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

<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: _____

**Performance Measure:**

**C.b.2 Number and percent of consumer directed services agencies who continue to meet contract requirements. N: Number of consumer directed services agencies who continue to meet contract requirements D: Number of consumer directed services agencies monitored**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Health and Human Services Contract Administration and Tracking System**

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

**Data Aggregation and Analysis:**

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Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 newly enrolled providers for whom the State conducted orientation with state requirements and the approved waiver. N: Number of newly enrolled providers meeting provider orientation requirements. D: Number of newly enrolled providers.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**DADS Contract Accountability and Oversight Internal 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample

		Confidence Interval =
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

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

C.a.1, C.a.2, C.b.1 and C.b.2 - DADS Regulatory is the entity that licenses the home and community support services agencies that provide respite and flexible family support services to MDCP individuals. DADS Regulatory staff and DADS contracts staff have ongoing communications regarding any potential actions on either licenses or contracts.

C.a.2 - 100 percent of contracted home and community support services agencies are monitored biennially by DADS. DADS monitors a certain number of home and community support services agency providers each year. This data is reported for the year in which the provider is monitored resulting in no overlaps in

reporting/monitoring.

C.b.2 - 100 percent of consumer directed services agencies are monitored every three years. DADS monitors a certain number of consumer directed services agencies each year. This data is reported for the year in which the provider is monitored resulting in no overlaps in reporting/monitoring.

**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.

Department of Aging and Disability Services Community Services Contracts staff is responsible for conducting monitoring reviews of all MDCP providers. Community Services Contracts staff completes the first monitoring between the ninth and twelfth month of the initial provider agreement/ contract; thereafter, it occurs at least every 24 months. Community Services Contracts staff responds to complaints received against a contractor for failure to maintain provider qualifications. The Department of Aging and Disability Services levies appropriate provider actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity.

DADS Community Services Contracts staff sends provider agreement/contract monitoring review findings to the provider. This report specifies when a corrective action plan is necessary and requires the provider to indicate the following:

How the corrective action plan will be accomplished for those affected by the deficiency, including who will be responsible for the action, what the action will be, what the action will accomplish, and when the action will be implemented;

How the provider will identify other participants with the potential to be affected by the same deficiency;

What measures will be put in place or systematic changes made to ensure the deficiency will not re-occur;

How the provider will monitor to ensure that the corrective action plan is implemented; and

How the corrective action plan will ensure that the deficiency is corrected.

Providers are informed that their failure to ensure that the State receives an acceptable corrective action plan by the date specified by the State may result in the State taking adverse action against the provider, up to and including termination of the provider agreement/contract.

Department of Aging and Disability Services Community Services Contracts staff provides guidance and technical assistance as needed or requested in the development of the plan of correction. The State monitors the corrective action plan until the provider is in compliance. Results of each on-site review are documented and recorded in a spreadsheet maintained in the state office.

Department of Aging and Disability Services Community Services Contracts staff refers providers with identified deficiencies to the Sanction Action Review Committee to determine if provider agreement/contract actions should be taken against the provider. Department of Aging and Disability Services Community Services Contracts staff submits provider agreement/contract action recommendations to the Sanction Action Review Committee for any provider who fails to meet a compliance level of at least 90 percent on monitoring reviews or when a complaint investigation against a provider substantiates a reported allegation. Sanction Action Review Committee members review the monitoring review results and, if applicable, complaint investigation findings to ensure the circumstances support the recommended provider agreement/contract action.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>

<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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

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### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

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### 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 D: Participant-Centered Planning and Service Delivery

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

**State Participant-Centered Service Plan Title:**  
Individual Plan of Care

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):
- Registered nurse, licensed to practice in the State**
  - Licensed practical or vocational nurse, acting within the scope of practice under State law**
  - Licensed physician (M.D. or D.O)**
  - Case Manager** (qualifications specified in Appendix C-1/C-3)
  - Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

The DADS case manager must have the:

- \* Ability to set priorities, establish timeframes and meet deadlines;
- \* Ability to establish and maintain effective relationships with individuals, co-workers, program provider staff, and staff from other federal and state agencies;
- \* Ability to operate computer and general office equipment;
- \* Knowledge of interviewing techniques to obtain personal information makes inquiries and resolve conflicting statements;
- \* Knowledge of community resources that serve individuals who are older or have a disability;
- \* Ability to effectively communicate orally and in writing;
- \* Education and/or experience indicating the DADS case manager possesses the knowledge, skills, and abilities necessary for job performance.

- 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:*

## 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.

**(a) Supports and information available to individual**

The DADS case manager or regional nurse or home and community services agency nurse as applicable supports the individual/parent/guardian in setting goals that address the needs identified during assessment and educates the individual about waiver and non-waiver service options available. The individual/parent/guardian and DADS case manager work together to develop an individual service plan that addresses the individual's goals and identifies providers, caregivers, and other third party resources that will contribute to goal achievement. The DADS case manager works with the individual/parent/guardian and other third party resources.

**(b) Individual's authority to determine who is included in the process**

The individual service plan is developed by the:

- individual;
- individual's parent or guardian;
- DADS case manager;
- DADS regional nurse or home and community support services agency nurse as applicable; and
- Any other person requested by the individual/parent/guardian, such as a provider, a school system representative, or other formal or informal support.

The individual/parent/guardian, the DADS case manager, regional nurse or home and community services agency nurse as applicable, and any designated representative sign the individual service plan.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (4 of 8)

**d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and

other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) The individual, the parent/guardian, the DADS case manager, DADS regional nurse or home and community support services agency nurse if applicable, and those chosen by the individual, develop the service plan. The DADS case manager must make initial contact and meet with an individual within 30 days of the individual's release off the interest list or request to apply for MDCP. The DADS case manager must complete the service plan within 30 days of the initial meeting with the individual. A re-evaluation is conducted annually and a service plan is developed for services for the next year. The individual, parent/guardian, designated representative, or provider on behalf of the individual can request changes in the service plan at any time. The DADS case manager or regional nurse discusses the requested service plan changes with the individual or the individual's representative and approves or denies the changes.

(b) The information gathered during the medical necessity and level of care assessment is used in developing the service plan. The DADS case manager works with the individual and representative to set goals to address caregiver relief, health care, social, and other support needs identified for and by the individual during the initial assessment. They develop a plan to achieve each goal, including those goals requiring non-waiver services that are otherwise important to the individual's health and well-being. The service plan must be consistent with the desires of the individual.

(c) The DADS case manager must educate the individual and representative about all waiver services as part of the service plan development.

(d) The service plan must reflect the goals, needs and preferences of the individual. The individual or representative must sign the plan to indicate understanding of and agreement with the service plan. If the individual does not agree with the service plan, the individual or representative may file an appeal.

(e) As part of care coordination, the DADS case manager must give the individual information about and referral to community organizations or third party resources that are otherwise important to the health and well-being of the individual. The DADS case manager, with support from the DADS regional nurse or home and community services agency nurse as applicable, is responsible for organizing medically and functionally necessary services to achieve the individual's goals, including those goals requiring non-waiver services that are otherwise important to the individual's health and well-being. The DADS case manager must provide any referrals specified within the service plan in an expeditious manner, and coordinate with the individual's family members, designated representative, or guardian, as well as providers of non-waiver services and other community resources, as reflected in the service plan.

(f) The service plan shall include services (e.g., units, frequency, etc), and the roles of the individual, DADS case manager, providers, family, and informal caregivers in achieving the goals and meeting the individual's needs, including health care needs. The DADS case manager is responsible for monitoring and overseeing the implementation of the service plan. The DADS regional nurse may assist with monitoring and overseeing the service plan. Monitoring and implementing the service plan requires that the DADS case manager maintain contact with the individual and their representative to ensure appropriate service delivery.

(g) The service plan can be updated at the request of the individual, the representative or the provider when the individual's condition changes. The service plan can be updated to reflect changes resulting from utilization review, and the individual may appeal any changes with which they disagree.

## **Appendix D: Participant-Centered Planning and Service Delivery**

### **D-1: Service Plan Development (5 of 8)**

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

During the service planning process, the DADS case manager, with support from the DADS regional nurse or home

and community support services agency nurse, if applicable, uses medical necessity and level of care assessment along with the individual/parent/guardian's input to determine any risks that might exist to health and safety as a result of living in the community. The development of back-up plans is an integral part of the service planning process. Back-up planning includes determining the availability of informal supports, third party resources, and other community resources.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The DADS case manager obtains a listing of providers who have contracted with DADS to provide MDCP services from the regional contract managers. The individual is offered a choice among the service providers contracted to provide MDCP services in the area. If the individual has no preferred provider, the DADS case manager assigns providers on a rotating basis. The DADS case manager must document in the case record the individual's choice regarding the provider.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The State Medicaid Agency (HHSC), through its executive directive, delineates roles and responsibilities of each department. The executive directive outlines HHSC's monitoring and oversight functions. HHSC, as the Single State Medicaid Agency, has an executive directive to DADS as the operating agency. The service planning process is a function which HHSC has delegated to DADS as the operating agency.

DADS reviews and approves or denies all service plans annually or when there is a need to revise the plan. DADS performs reviews of each agency provider every two years and consumer directed service agencies at least every three years to monitor that services in the service plan are delivered. DADS annually aggregates data and reports to HHSC.

HHSC discusses with DADS any significant findings and together with DADS reviews remediation activities and prepares improvement plans as needed.

## 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:*

Providers.

## **Appendix D: Participant-Centered Planning and Service Delivery**

### **D-2: Service Plan Implementation and Monitoring**

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a) The DADS case manager is responsible for assessing how well services are meeting an individual's needs and enabling the individual to achieve the goals described in the service plan. The DADS regional nurse may assist with monitoring.

(b) The DADS case manager must contact the individuals in person or by telephone at least every six months. The individual's access to services and satisfaction with services are reviewed during the six months contact. The back-up plan is reviewed at each six month contact.

(c) The DADS case manager monitors the implementation of the service plan at regular intervals by contacting the individual/parent/guardian. The DADS case manager in consultation with the DADS regional nurse or home and community support services agency nurse, if applicable, must re-evaluate the appropriateness of the service plan whenever the individual's condition changes significantly or upon request of the individual.

DADS case managers are responsible for assuring the plan is reviewed thirty days after the effective date, at least every six months, and annually, and is revised whenever indicated by a change in service needs. DADS case managers must take appropriate actions to resolve issues noted during the contact. During the monitoring contact, DADS case managers are responsible for determining if any existing situations jeopardize the individual's health and welfare. Additional contacts by the DADS case manager may be scheduled to protect the individual's health and welfare.

The DADS case manager must review and document the following:

- Whether or not waiver and non-waiver services and supports are implemented and provided in accordance with the service plan and continue to meet the individual's needs, goals, and preferences;
- Whether or not the individual is satisfied with implementation of services;
- Whether or not the individual's health and welfare are reasonably assured;
- Whether or not the individual exercises free choice of providers and accesses non-waiver services, including health services;
- For individuals who select the traditional agency model, whether or not the agency exercised the alternate service delivery plan as required by MDCP rules in the absence of the regularly scheduled agency staff; and
- For individuals who self-direct service delivery, whether or not the individual implemented the backup plan, and, if so, whether or not the backup plan was effective.

Results of monitoring reviews are documented in the case file via the individual plan of care service review form.

The DADS case manager takes appropriate actions to address identified problems including counseling with the individual; convening a meeting with the individual, caregiver, and others contributing to the individual's care to resolve problems; and advocating on the individual's behalf with the provider or non-waiver service. When the DADS case manager or regional nurse identifies changes in needs or preferences while monitoring the service plan, the DADS case manager may convene a meeting with the individual, the caregiver, and others contributing to the individual's care to address problems or identified changes. The DADS case manager may also confer with providers concerning improving implementation strategies. If a self-directing individual's backup plan was not effective, the DADS case manager, the individual, and the caregiver determine the revisions that should be made to the plan. The DADS case manager must document in the individual's record that the plan was effective or that revisions were required. The DADS case manager assures that the backup plan is revised whenever necessary.

- 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:*

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## Appendix D: Participant-Centered Planning and Service Delivery

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### 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**
  - 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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#/% of individuals'(ind)case records that reflect the service plan addressed all the ind assessed needs and personal goals either by the provision of waiver services or through other means.N:#of ind case records that reflect the service plan addressed all the ind assessed needs and personal goals either by the provision of waiver services or through other means.D:#of ind case records reviewed**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**DADS - Community Care Case Reading System**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95% +/- 5%
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>	<input checked="" type="checkbox"/> <b>Stratified</b> Describe Group: Regions
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**D.a.2. #/% of individuals' case records that reflect the service plan addressed health and safety risk factors, either by the provision of waiver services or through other means. N: # of individuals' case records that reflect the service plan addressed health and safety risk factors, either by the provision of waiver services or through other means. D: # of individuals' case records reviewed.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**DADS - Community Care Case Reading System**

<b>Responsible Party for</b>	<b>Frequency of data</b>	<b>Sampling Approach</b>
------------------------------	--------------------------	--------------------------

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

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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** The number and percent of individuals  service plans that reflect the service plan was developed in accordance with the State's policies and procedures. N: number of individuals with service plans developed in accordance with State's policies and procedures D: number service plans reviewed

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DADS - Community Care Case Reading System**

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

**Data Aggregation and Analysis:**

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Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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' case records that reflect service plans are updated annually. N: Number of individuals' case records that reflect service plans are updated annually. D: Number of individuals' case records reviewed.**

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**DADS - Community Care Case Reading 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative

		<b>Sample</b> Confidence Interval = 95% +/- 5%
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>	<input checked="" type="checkbox"/> <b>Stratified</b> Describe Group: _____ Regions _____
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**D.c.2. Number and percent of individuals' case records that reflect service plans were revised when warranted by reported changes in the individuals' needs. N: Number of individuals' case records that reflect service plans were revised when warranted by reported changes in the individuals' needs. D: Number of individuals' case records reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DADS - Community Care Case Reading System**

<b>Responsible Party for data collection/generation</b>	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
---	---	---

<i>(check each that applies):</i>		
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95% +/- 5%
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>	<input checked="" type="checkbox"/> <b>Stratified</b> Describe Group: Regions
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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 The number and percent of individuals  case records that reflect services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan. N: number of individuals' case records that reflect services are delivered in accordance with their service plan D: number of individuals reviewed**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**DADS - Community Care Case Reading System**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data</b>	<b>Frequency of data aggregation and</b>
-----------------------------------	--

<b>aggregation and analysis</b> (check each that applies):	<b>analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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' case records that reflect individuals are afforded choice between waiver services and institutional care and choice of waiver services. N: Number of individuals' case records that reflect individuals are afforded choice between waiver services and institutional care and choice of waiver services. D: Number of individuals' case records reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DADS - Community Care Case Reading System**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95% +/- 5%
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>	<input checked="" type="checkbox"/> <b>Stratified</b> Describe Group: Regions
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**D.e.2 Number and percent of individuals whose case records reflect individuals are afforded choice between waiver providers. N: Number of individuals whose case records reflect individuals are afforded choice between waiver providers. D: Number of individuals' case records reviewed.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**DADS - Community Care Case Reading System**

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

<b>collection/generation</b> <i>(check each that applies):</i>	<i>(check each that applies):</i>	
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95% +/- 5%
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>	<input checked="" type="checkbox"/> <b>Stratified</b> Describe Group: Regions
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

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

From October 2009 to November 2009, 1,137 Children/Family surveys were mailed to families of children receiving services through MDCP. 186 surveys were returned for a return rate of 16.4 percent. The purpose of the survey was to obtain information directly from families about their experiences using DADS programs and services for their children. Future surveys will provide additional data that will enable DADS staff to trend and analyze over time to identify areas for improvement and to measure if improvement strategies are being effective. Future surveys will be conducted every even numbered year. In addition, lessons learned during the implementation of this initial project will enable the Department of Aging and Disability Services to identify areas of process improvement. The National Core Indicator Children/Family Survey data will be considered in the Department of Aging and Disability Services overall quality management strategy addressing quality of services in MDCP. The Department of Aging and Disability Services will use the data to identify where individuals are having positive experiences, as well as to identify areas that warrant further exploration.

**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.

Monitoring by case managers: DADS case managers are responsible for monitoring the implementation of service plans and for coordinating all services, waiver and non-waiver, that individuals receive. DADS case managers may need to consult with providers of State Plan services, as well as community resources, to ensure that all needs are being met, that there is no duplication of services, and that the services are being provided in accord with the service plan.

The DADS MDCP case manager discusses the MDCP backup plan at the 30-day monitoring review which takes place after services begin. The DADS MDCP nurse reviews the back-up plan during the face-to-face annual reassessment visit and at the 6 month monitoring. The DADS case manager makes sure the plan is revised at least annually, or whenever indicated by changes in the individual's service needs. DADS case managers must take appropriate actions to resolve issues noted during the contact. During the monitoring contact, DADS case managers are responsible for determining if any existing situations jeopardize the individual's health and welfare. Additional contacts by the DADS case manager may be scheduled to protect the individual's health and welfare. As necessary, DADS case managers enter updates to the service plan into the Service Authorization System.

Case reading: DADS reviews applicant/individual case records in order to review and monitor case reading statistics on a statewide level, identify significant trends and anomalies, and implement appropriate performance improvement plans. The Community Care Case Reading System serves as the basis for determining compliance with performance evaluation standards for both individual case managers and for the regions. The Community Care Case Reading System automates the sample selection process, which standardizes how cases are selected across units and regions. The DADS case managers must correct cases containing errors (as identified by a validation report) within thirty days from the date of that report. The DADS regional staff is responsible for ensuring that the cases have been corrected.

Providers: Home and community support services agencies and other providers, as applicable, are responsible for ensuring implementation of the service plan. Home and community support services agencies are responsible for conducting semiannual nursing assessments to identify individual needs and request changes to the service plan accordingly. Deficiencies in service monitoring or implementation noted during the DADS monitoring reviews are entered into the Contracts Oversight and Support database.

Provider Monitoring Reviews: Contract monitoring is conducted annually on a percentage of providers and can also be intermittent given complaint investigations. When the Department of Aging and Disability Services detects provider non-compliance with provider policy and rules, it requires the provider to implement corrective action. On-site technical assistance is available. Following monitoring reviews, providers receive a written report detailing the specific areas of noncompliance found during the review, including instruction regarding the provider's responsibility to remediate areas of deficiency. The State conducts follow-up reviews in accordance with monitoring procedures to ensure corrective action has been implemented.

Findings resulting from monitoring are reviewed by the Department of Aging and Disability Services Sanction Action Review Committee to determine if actions should be taken against the provider or consumer directed services agency, including a program improvement plan, consumer hold, vendor hold and/or termination.

Consumer directed services: Individuals who utilize the consumer directed services option are responsible

for ensuring implementation of participant-directed services. With approval of the consumer directed services agency, the employer may make revisions to a specific service budget that do not change the amount of funds available for the service in the approved service plan. Revisions to the service plan amount available for a particular service, or a request to shift funds from one self-directed waiver service component to another, must be justified by the employer's service planning team, authorized by DADS, and updated in the Service Authorization System. With assistance of the consumer directed services agency, the employer revises the consumer directed services budget to reflect a revision in the service plan. Deficiencies in service plan monitoring or implementation noted during the Department of Aging and Disability Services annual or intermittent on-site reviews of program providers are entered into a database.

ii. **Remediation Data Aggregation**

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

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

D.a.2.- Forms used to gather this data are being updated. Expected completion date is March 1, 2013. Data will be available September 1, 2013. If changes are needed to this performance measure, at that time the State will submit an amendment.

D.c.1. and D.c.2.- A request is pending with DADS Information Technology to obtain the appropriate data. Expected completion date is March 1, 2013. Data will be available September 1, 2013. If changes are needed to these performance measures, at that time the State will submit an amendment.

## 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: respite, financial management services, and flexible family support services.

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 consumer directed services agency, chosen by the individual or legally authorized representative.

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 consumer directed services agency, budgets approved funds for self-directed services.

The DADS 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 consumer directed services agencies.

Supports for the individual directing services or the individual's legally authorized representative include:

1. The DADS case manager, who provides information about the consumer directed services option and monitors service delivery. The DADS case management functions are global and apply to self-directed as well as provider-managed waiver services and non-waiver services;
2. A consumer directed services agency, chosen by the individual or legally authorized representative, to provide financial management services. The consumer directed services agency must hold a Medicaid provider agreement (contract) with DADS on behalf of HHSC.

Supports may also include 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 consumer directed services agency;
2. Participate in orientation and ongoing training conducted by the consumer directed 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 participants 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*

An 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 respite, financial management services, or flexible family supports.

## Appendix E: Participant Direction of Services

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### 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 DADS 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 and at each annual review of the service plan or 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 service 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 DADS 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, DADS case manager, and the consumer directed 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

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### 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 a non-legal representative adult 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 consumer directed services agency. The consumer directed 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.

## 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.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Flexible Family Support Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Respite	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

## 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 C1/C3**

**The waiver service entitled:  
Financial Management Services**

- FMS are provided as an administrative activity.**

#### Provide the following information

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

Private entities furnish financial management services. These entities, called consumer directed 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 consumer directed 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.

- 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:

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- Assists participant in verifying support worker citizenship status**  
 **Collects and processes timesheets of support workers**  
 **Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**  
 **Other**

*Specify:*



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Supports furnished when the participant exercises budget authority:

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- Maintains a separate account for each participant's participant-directed budget**  
 **Tracks and reports participant funds, disbursements and the balance of participant funds**  
 **Processes and pays invoices for goods and services approved in the service plan**  
 **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**  
 **Other services and supports**

*Specify:*



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Additional functions/activities:

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- Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**  
 **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**  
 **Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**  
 **Other**

*Specify:*

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

HHSC has delegated to DADS the responsibility of executing Medicaid provider agreements, including day

to day operations of financial management services and monitoring of consumer directed services agencies. DADS conducts monitoring reviews of each consumer directed 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 consumer directed services agencies are providing financial management services. Texas monitors 100 percent of the consumer directed services agencies at a minimum every three years. DADS reports the results of the monitoring to HHSC.

DADS assesses a consumer directed 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:*

- 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
Adaptive Aids	<input type="checkbox"/>
Flexible Family Support Services	<input type="checkbox"/>
Financial Management Services	<input checked="" type="checkbox"/>
Transition Assistance Services	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Minor Home Modifications	<input type="checkbox"/>

- 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:*

Through a delegation agreement with the Health and Human Services Commission, the State Medicaid Agency, DADS employees provide case management and they are claimed at 50 percent administrative

funds. To prevent duplication of claims, financial management services providers, by rule, are prohibited from providing case management.

DADS case managers are responsible for providing each individual or legally authorized representative information sufficient to assure informed decision-making and understanding of the consumer directed services option and of the traditional provider-managed service delivery option. The information includes the responsibilities and choices individuals can make with the election of the consumer directed service option. DADS case managers review the consumer directed services option at program enrollment, at least annually, or upon request.

Information provided orally and in writing to the individual and the legally authorized representative by the DADS case manager includes:

1. An overview of the consumer directed services option;
2. Explanation of responsibilities of the individual or individual's legally authorized representative and the consumer directed services agency in the consumer directed services option;
3. Explanation of benefits and risks of participating in the consumer directed services option;
4. Self-assessment for participation in the consumer directed services option;
5. Explanation of required minimum qualifications of service providers through the consumer directed services option; and
6. Explanation of employee/employer relationships that prohibit employment under the consumer directed services option.

DADS conducts monthly case reading of a sample of cases for each DADS case manager performing this function. Designated case reading staff assess the case records for evidence that each individual was offered the option to use consumer directed services option instead of the agency option at the initial authorization for services and each annual review thereafter.

## Appendix E: Participant Direction of Services

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### 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:*

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## Appendix E: Participant Direction of Services

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### 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 DADS 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 consumer directed 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 DADS 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 provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

An individual's service planning team, consumer directed services agency, or DADS may recommend termination of participation in the consumer directed services option. If an individual, legally authorized representative, or designed 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;
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, Texas Administrative Code, Part 1, Chapter 41).

The DADS 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 consumer directed 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

Waiver Year	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
	Number of Participants	Number of Participants
Year 1		2406
Year 2		2501
Year 3		2597
Year 4		2693
Year 5		2788

## Appendix E: Participant Direction of Services

## E.4. Opportunities for Participant Decision Making (10%)

- a. **Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

- i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

- Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

- ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- Recruit staff**  
 **Refer staff to agency for hiring (co-employer)**  
 **Select staff from worker registry**  
 **Hire staff common law employer**  
 **Verify staff qualifications**  
 **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Funds available in the individual's consumer directed services budget are used for this purpose.

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**  
 **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**  
 **Determine staff wages and benefits subject to State limits**  
 **Schedule staff**  
 **Orient and instruct staff in duties**  
 **Supervise staff**  
 **Evaluate staff performance**  
 **Verify time worked by staff and approve time sheets**  
 **Discharge staff (common law employer)**  
 **Discharge staff from providing services (co-employer)**  
 **Other**

Specify:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (2 of 6)

**b. Participant - Budget Authority** Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

**i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget**
- Determine the amount paid for services within the State's established limits**
- Substitute service providers**
- Schedule the provision of services**
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- Identify service providers and refer for provider enrollment**
- Authorize payment for waiver goods and services**
- Review and approve provider invoices for services rendered**
- Other**

Specify:

## 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 consumer directed 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 consumer directed services agency prior to implementation. The consumer directed 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 consumer directed services agency, the individual or legally authorized representative may make revisions to a specific service budget that does not change the amount of funds available for the service based on the approved service plan.

Employer-related costs are paid for 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 consumer directed 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.

Information concerning budget methodology for the consumer directed services budget is available to the public in the Texas Administrative Code.

## Appendix E: Participant Direction of Services

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### 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. They are apprised of the budget as it is developed. The individual develops the consumer directed services budget based on the finalized service plan and authorized budget.

The consumer directed services agency and the DADS case manager inform the individual/employer of the amount authorized for the particular service before the budget is developed. The individual/employer may request an adjustment to the budget at any time, subject to cost limits. When DADS denies an individual/employer request for an adjustment to the budget, the individual/employer is entitled to a fair hearing. The procedures for a fair hearing are provided in Appendix F, Individual Rights.

## Appendix E: Participant Direction of Services

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### 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

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### 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 consumer directed services agency is required to monitor payroll every pay period (two weeks) and expenditures (as processed for payment) and report over- and under-utilization to the employer and the DADS case manager. When an over- or under-utilization is not corrected by the individual or legally authorized representative, the consumer directed services agency notifies the DADS case manager and the employer. The DADS case manager and the individual 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

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### 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 DADS 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, service termination, transfer, suspension, or denial of services.

If services are reduced, denied, suspended 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 notice to the individual or legally authorized representative that outlines the fair hearing procedure. This notice informs the individual of the opportunity to request a fair hearing. The notification explains the individual's right of appeal, and the right to have others represent the individual, including legal counsel. The DADS case manager 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 State's notice of adverse action and opportunity to request a fair hearing. The notice informs an individual or legally authorized representative whether or not the individual is eligible to receive or continue to receive services while the individual's appeal is under consideration and the actions that the individual must take in order for current services to continue. If an individual or legally authorized representative elects to request a fair hearing, DADS and the provider retain a copy of the individual's written request for a hearing in the individual's record. Individuals or legally authorized representatives must request a fair hearing within 12 calendar days of the date of the notice. During the fair hearing process, services continue at the level provided prior to denial and until the fair hearing process is complete, if the appeal is filed within 12 calendar days of the notice.

If an individual requests a fair hearing, DADS notifies the HHSC hearings officer. DADS sends the request to the HHSC hearings officer within five calendar days after the date DADS receives the request for appeal.

The HHSC hearings officer notifies the appellant and DADS of the request for a hearing and sets a time, date, and place for the hearing. DADS sends a copy of the notice and copies of all relevant documentation to all known parties and required witnesses within five calendar days of receipt of the notice from the HHSC hearings officer. The HHSC hearings office files the decision in the appeal file. DADS will implement the decision of the HHSC hearings officer within ten calendar days of the date of the decision and sends confirmation to the HHSC hearings office documenting 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 legally authorized representative, their families 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. The complaints 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, 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 enrollment in the waiver, the DADS 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. 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 contracted to provide waiver services, to DADS Regulatory Services and DADS Community Services Contract Accountability and Oversight. 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 Consumers 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 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.

Each DADS Community Services Contracts office maintains a complaint log for the purpose of collecting, reviewing and reporting complaint information. On a monthly basis, state office and each region compile the Complaint Activity Report and the Complaint Resolution Activity Report and post the reports electronically to a designated regional or state office specific 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 nursing facilities which DADS investigates, complaints involving allegations of the abuse, neglect, or exploitation of an individual 18 years of age or older 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. For individuals under age 18 years of age receiving waiver services, DADS investigates allegations of abuse, neglect and exploitation. Home and community support services agencies are required to report allegations of abuse, neglect or exploitation to 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 does not apply to home and community support services agencies; however, it does apply to 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).

DADS licensing and contracting rules contain requirements related to reporting incidents and complaints. DADS regularly monitors a provider's compliance with these requirements.

DADS licenses the following providers: Home and community support services agency providers (Title 40 of the Texas Administrative Code, Part 1, Chapter 97); Nursing Facilities providing out-of-home respite (Title 40 of the Texas Administrative Code, Part 1, Chapter 19); adult day care facilities (Title 40 of the Texas Administration Code, Part 1, Chapter 98) and Day Care Facilities (Title 40 of the Texas Administrative Code, Part 19, Chapter 745).

The Texas Department of State Health Services licenses: Hospitals providing out-of-home respite (Title 25 of the Texas Administrative Code, Part 1, Chapter 133); Specialty Care Facilities (Title 25 of the Texas Administrative Code, Part 1, Chapter 125); and Camps (Title 25 of the Texas Administrative Code, Part 1, Chapter 265, Subchapter B).

All unlicensed providers and home and community support services agencies are required to report any instances of

abuse, neglect, or exploitation of an individual, as defined in the Texas Human Resources Code §48.002, to the Department of Family and Protective Services immediately upon suspicion of such activities. The Department of Family and Protective Services investigate assigned reports and make a determination as to whether abuse, neglect, or exploitation occurred. In some instances, the Department of Family and Protective Services may offer services.

For individuals under age 18 years of age receiving waiver services, DADS investigates allegations of abuse, neglect and exploitation. All licensed providers are required to report allegations of abuse, neglect, and exploitation directly to DADS immediately upon suspicion of such activities.

Providers make the reports of suspected abuse, neglect, or exploitation by telephone to either the State abuse hotline or the licensing complaint hotline. Individuals may also report suspected instances of abuse, neglect, or exploitation using either telephone number 24 hours a day.

DADS requires licensed providers to have a disaster preparedness plan in place. During the DADS Regulatory Services survey, the disaster plan is reviewed to ensure compliance with licensing requirements.

- 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 the individual is enrolled in MDCP, providers must ensure that the individual is informed orally and in writing of the processes for reporting allegations of abuse, neglect, or exploitation. The toll-free numbers for DADS and Department of Family and Protective Services must be provided. Facilities must post the information in a conspicuous place. Home and community support services agencies must provide the information to the individual at the time of admission. Evidence supporting compliance with these requirements is reviewed during DADS on-site licensure surveys and contract monitoring reviews of the program provider.

The DADS case manager plays a role in ensuring that individuals receive training and education regarding protections from abuse, neglect, and exploitation. DADS case managers advise individuals of their rights to freedom from abuse, neglect, and exploitation and ensure that the individuals read and sign the Consumer Rights and Responsibilities form.

In addition to the information provided to all individuals in the waiver, a consumer directed services agency provides individuals electing the consumer directed services option with training and written information related to reporting allegations of abuse, neglect, and exploitation.

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

The Department of Family and Protective Services is responsible for receiving and investigating reports of abuse, neglect, and exploitation for all individuals 18 years of age or older served by unlicensed providers or home and community support services agencies.

For individuals under age 18 years of age receiving waiver services, DADS investigates allegations of abuse, neglect and exploitation. DADS is the investigative authority for allegations for abuse, neglect, and exploitation involving licensed facilities.

The Department of Family and Protective Services assigns a priority level to a complaint at the time of intake based on the perceived threat level to the individual. The Department of Family and Protective Services must initiate a case by contacting a person with current and reliable information within 24 hours of intake and must conclude the investigation within 30 days. The investigator may change the priority level based on information from the 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. The results of the investigation are reported to the complainant and other pertinent parties within 30 days by generating a letter from their automated system.

Texas Human Resources Code Chapter 48 requires that the Department of Family and Protective Services investigate persons thought to have knowledge of the circumstances regarding abuse, neglect, and exploitation. Texas Human Resources Code also provides certain laws to assist with investigations including access to records and a prohibition against interference with investigation or services.

- e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible

for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

In accordance with 42 Code of Federal Regulations, §431.10(e), HHSC is the Single State Medicaid Agency and retains oversight and full administrative authority over the waiver program. DADS is the operating agency for the MDCP waiver program.

The Department of Family and Protective Services is also involved in administrative and operation activities. DADS and the Department of Family and Protective Services are part of the Texas health and human services enterprise. The Department of Family and Protective Services is responsible for handling all reports of abuse, neglect, and exploitation related to adults receiving services in the community, including adults served by a home and community support services agency licensed under Health and Safety Code, Chapter 142, except for those occurring in a facility subject to licensure by DADS.

As required by Texas Human Resources Code, §48.103, 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 the Department of Family and Protective Services due process procedure has been completed, the Department of Family and Protective Services Adult Protective Services caseworker 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. The investigative findings and DADS follow-up on those findings is entered into the abuse, neglect, or exploitation database by DADS staff. Reports of critical incidents are compiled on a monthly basis for each program provider.

In preparation for annual 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 provider.

DADS is responsible for all other critical events and incidents. All critical events and 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 or exploitation is monitored, tracked and trended for purposes of training DADS staff and to prevent recurrence.

Providers are responsible for training their staff about reporting critical incidents and events.

## Appendix G: Participant Safeguards

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

#### a. Use of Restraints or Seclusion. *(Select one):*

- The State does not permit or prohibits the use of restraints or seclusion**

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

Complaints concerning any use of restraint can be made to DADS or Department of Family and Protective Services. The DADS case manager and the MDCP 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 MDCP services including:

The toll-free telephone number of DADS Consumer Rights and Services to file a complaint; and

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

DADS monitors potential improper use of restraints through on-site surveys and complaint investigations.

- The use of restraints or seclusion 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 or Seclusion.** 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 or 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 restraints or 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-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

- 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 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 of the right to discontinue use of the restrictive intervention at any time.
- Allowance for a revised plan, when the restrictive intervention is not working.
- The effects of the techniques in relation to the individual's health and welfare must be considered.
- The individual's 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 at least annually.

Each person who is to use the restrictive intervention must be trained in the proper use and 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 DADS case manager and the MDCP 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 MDCP 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 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 DADS case manager and the MDCP 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 MDCP 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-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.

- 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.

## Appendix G: Participant Safeguards

**Appendix G-3: Medication Management and Administration (2012)**

**c. Medication Administration by Waiver Providers**

**Answers provided in G-3-a indicate you do not need to complete this section**

**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).
- 

**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:

---

- 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.
-

## 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, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.*

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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 the victim in a report of abuse, neglect or exploitation.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Home and Community Support Services Agencies Intake Tracking System / Compliance Assessment Regulation Enforcement System**

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

	<input type="checkbox"/> <b>Other</b> 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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

**Performance Measure:**

**G.a.2 Number & percent families who reported being familiar with the process for filing a complaint or grievance regarding services they receive or staff that provides the services they receive. N:number of families who reported being familiar with the process for filing a complaint or grievance regarding services they receive or staff that provides the services they receive D:number of families**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Child and Family National Core Indicators**

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):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95/5

<input type="checkbox"/> <b>Other</b> Specify: <hr/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <hr/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <hr/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: Bi-annually	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**G.a.4. 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:

**DADS - Community Care Case Reading**

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

		Confidence Interval = 95% +/- 5%
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>	<input checked="" type="checkbox"/> <b>Stratified</b> Describe Group: Regions
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> 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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: _____

**Performance Measure:**

**G.a.5. Number and percent of priority one complaints resolved by DADS Regulatory Services according to DADS policy. N: Number of priority one complaints resolved by DADS Regulatory Services according to DADS policy. D: Number of priority one complaints received.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Compliance Assessment Regulation Enrollment System / Home and Community Support Services Agencies Intake 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):
<input type="checkbox"/> <b>State Medicaid</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**G.a.6 Number and percent of individuals who receive monitoring visits according to policy and the waiver application. N: number of individuals reviewed who received monitoring visits according to policy and the waiver application D: number of individuals reviewed.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**DADS - Community Care Case Reading System.**

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**G.a.7.#/%of individuals for which utilization review(UR)identified a lack of hands-on**

service provision or time/schedule change that did not result in a negative impact or there was not a potential for a negative impact on the individual. N:"Repeat of performance measure". D:#of individuals where UR identified that hands-on services were not provided as indicated on the service plan

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**DADS Utilization Management and Review**

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

**Data Aggregation and Analysis:**

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

**Other**  
Specify: \_\_\_\_\_

**Performance Measure:**

**G.a.8. Number and percent of individual case records that reflect the individual has a current backup plan. N: Number of individual case records that reflect the individual has a current backup plan. D: Number of individuals' case records reviewed.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**DADS - Community Care Case Reading**

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

**Data Aggregation and Analysis:**

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

	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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:

**Home and Community Support Service Agencies Intake Tracking System / Compliance Assessment Regulation Enforcement System**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>

<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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.

In accordance with state law, DADS maintains an Employee Misconduct Registry that includes the names of persons DADS or the Texas Department of Family and Protective Services has confirmed to have abused, neglected, or exploited an individual receiving services.

In addition, in accordance with federal law, the State 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. Program providers and local authorities must consult these registries prior to offering employment to a non-licensed service provider and refrain from employing that person if either registry indicated the person was confirmed to have abused, neglected, or exploited an individual receiving services.

Texas state law prohibits providers from employing a person whose criminal background indicates the person has been convicted of certain felonies. Providers are required to complete pre-employment criminal background checks for each non-licensed persons who will provide services to an individual enrolled in the MDCP program. Providers must also 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 individuals and entities; and immediately report any discovered exclusion information to HHSC-Office of Inspector General using the self-reporting mechanism located on the HHSC-Office of Inspector General website at: [https://oig.hhsc.state.tx.us/ProviderSelfReporting/Self\\_Reporting.aspx](https://oig.hhsc.state.tx.us/ProviderSelfReporting/Self_Reporting.aspx).

Providers must maintain documentation to verify compliance with the search and at minimum, documentation elements must include:

- date of the federal and state database searches;
- first and last names and date of birth of all employees and contractors subject to the state and federal lists of excluded individuals and entities search requirements;
- whether or not the employee/contractor appeared in the state and federal lists of excluded individuals and entities databases;
- date any excluded employee/contractor was self-reported to HHSC-OIG;
- copy of the self-report; and
- printed name(s) and signatures of staff responsible for completing the monthly searches.

DADS requires all contracted providers to maintain documentation to verify completion of the monthly searches and reporting of any exclusion information to HHSC-Office of Inspector General. Providers must maintain this documentation for a minimum of six years after the end of the federal fiscal year in which the searches were completed and any exclusion information reported to HHSC-Office of Inspector General. Providers are not required to maintain documentation of the search results for individuals who do not appear in the federal or state lists of excluded individuals and entities.

The Quality Assurance and Improvement unit of DADS will continue its Child and Family National Core Indicators survey project with the individuals who participate in home and community-based service programs operated by the State. The Child and Family National Core indicators survey began in 2005 for MDCP individuals and is conducted biennially. As a part of the Child and Family National Core Indicators survey, individuals who receive services in MDCP may respond to indicators regarding health, welfare and rights. The State will use findings to update MDCP Quality Improvement Strategy as necessary. Findings from the Child and Family National Core Indicators survey will be provided to HHSC each year the survey is administered.

G.a.7 -Utilization Review uses a representative sample and the performance measure is a subset of the representative sample. 100% of the subset is reviewed.

**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.

As part of the monitoring review, DADS Community Services Contracts staff verifies that the provider informed each individual or the individual’s representative of the procedures for filing complaints, including the name, title, and telephone number of the person to call in the event the individual or representative wishes to make a verbal complaint. DADS Community Services Contracts staff reviews a provider’s complaint procedures to ensure that the provider investigates complaints according to standard complaint procedures. DADS requires providers are required to maintain a complaint log and investigate/resolve complaints according to DADS Community Services complaint procedure rules.

DADS Community Services Contracts staff conducts complaint investigations which involve the waiver 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. Priority one complaints must be investigated within 24 hours.

DADS Community Services Contracts staff informs providers of complaint findings at the conclusion of the investigation and 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 develop and implement an immediate corrective action plan.

The DADS Sanction Action Review Committee reviews all substantiated allegations. 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.

The Department of Family and Protective Services-Adult Protective Services records and tracks abuse, neglect, and exploitation reports in its Information Management Protecting Adults and Children in Texas system. DADS staff coordinates with the Department of Family and Protective Services-Adult Protective Services staff to determine the resolution of the abuse, neglect or exploitation allegation. Providers are required to protect individuals from abuse, neglect or exploitation under individual rights rules and report potential incidences of abuse, neglect or exploitation.

Mortality reviews are done in 208 Texas counties and 94.6 percent of Texas children live in a community where child deaths are reviewed. Every child death related to abuse, neglect, or suspicious circumstances is investigated; however not every county has a death review committee.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b>	<input checked="" type="checkbox"/> <b>Annually</b>

Specify:  	
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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.

G.a.3 was removed based on agreement with CMS. Renumbering of the performance measures in the portal will occur with the next amendment.

G.a.4 - Forms used to gather this data are being updated. Expected completion date is March 1, 2013. Data will be available September 1, 2013. If changes are needed to this performance measure, at that time the State will submit an amendment.

## **Appendix H: Quality Improvement Strategy (1 of 2)**

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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 QMS 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 QMS* 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 QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

## Appendix H: Quality Improvement Strategy (2 of 2)

### 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( <i>check each that applies</i> ):	Frequency of Monitoring and Analysis( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> 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 primarily from the DADS Quality Assurance and Improvement Data Mart that includes data on 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 DADS Center for Policy and Innovation maintains the DADS Quality Assurance and Improvement Data Mart which 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 MDCP in writing and at meetings of the Medical Care Advisory Committee, the DADS Advisory Council, and the HHSC Advisory Council. The Department of Aging and Disability Services 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, state staff will evaluate the processes and indicators of the Quality Oversight Plan. State staff will examine issues such as whether or not the indicators are providing substantive information about each sub-assurance and whether the Quality Review Team composition is inclusive of key agency stakeholders. If areas for improvement exist, State 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, billing and payment reviews, to ensure that the MDCP providers and consumer

directed services agencies are complying with program requirements. DADS conducts fiscal monitoring of MDCP providers on-site at least every two years and typically reviews a two month sample of the provider's records and at a minimum three years for on-site for consumer directed services agencies and typically reviews a six-month sample of consumer directed services agencies' records, but 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/CDSA's service delivery records with its billing records to verify that payments DADS made to the provider or consumer directed services agency were appropriate and for services provided in compliance with the provider's contract with DADS and with the rules and regulations for those services;
- \* Service plans and records; and
- \* Comparison of service delivery and other supporting documentation with service plans.

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 failure to comply with the contract terms.

The provider must provide the detailed 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.***

##### i. Performance Measures

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**I.a.2** The number and percent of provider claims that are processed within three business days after receipt of the claim. **N:** number of provider claims that are processed within three business days after receipt of the claim. **D:** number of provider claims.

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**Texas Medicaid and Healthcare Partnership Monthly Status Reports**

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

**Data Aggregation and Analysis:**

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

<input type="checkbox"/> <b>Other</b> 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.

Program providers enter billing claims into the Claims Management System, which assigns the correct reimbursement rate associated with the billing code entered by a program provider.

The State's Claims Management System is a comprehensive claims processing system for providers. This system supports electronic and paper claims submissions and has numerous edits to assure that providers submit accurate billings. Providers are unable to submit billing claims for any service components until the State has authorized the plan and the authorized plan has been entered into the Service Authorization System.

Most providers submit claims electronically to the State's contracted Medicaid Management Information System through a computer software application called TexMedConnect or develop third-party software that meets CMS requirements. Some providers submit paper claims to the State's contracted Medicaid Management Information System using a standard claim form.

The State's contracted Medicaid Management Information System sorts and images all paper claims before the State's contracted Medicaid Management Information System claims staff enters the claims into the Claims Management System. Once the electronic or paper claim is entered into the Claims Management System, the system assigns the correct reimbursement rate associated with the billing code entered by the provider.

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 on 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 authorized in the Service Authorization System. The Claims Management System also automatically rejects any claim that is entered with an unauthorized billing code.

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.

When the State detects provider non-compliance with the program billing guidelines, the agency requires the provider to implement corrective action.

Following billing and payment reviews, all providers receive a written review report that details the specific areas of non-compliance found during the review and includes instruction regarding the provider's responsibility with regard to the areas of deficiency.

The State then conducts follow-up activities in accordance with MDCP provider review procedures and consumer directed services agency review procedures to ensure corrective action has been implemented. The State recoups funds when claims for services to individuals were found in error.

- ii. **Remediation Data Aggregation**

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

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

Texas Health and Human Services Commission (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 will use existing service rate methodologies from other home and community-based services waivers to set service rates for MDCP. The rates for the MDCP program are available on the Rate Analysis webpage located at <http://www.hhsc.state.tx.us/rad/long-term-svcs/medically-dependent-children-program/index.shtml>.

HHSC models the rates for, flexible family support services and respite (in all settings) from other Medicaid home and community-based services waiver programs that use cost reports to determine rates.

Providers of these services are required to submit annual cost reports to HHSC. 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 reviews all cost reports and a sample of cost reports are 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; 4) payroll taxes and benefits are allocated to each salary item; 5) total projected allowable costs are divided by the number of units of service to determine the projected cost per unit of service; 6) the allowable costs per unit of service for each contracted provider are arrayed and weighted by the number of units of service and the cost per unit of service is calculated; and 7) the cost per unit of service for each waiver service is multiplied by an incentive factor to ensure the rates cover the costs of economic and efficient providers.

When historical costs are unavailable such as in the case of changes in program requirements, payment rates may be based on a pro forma approach. This approach involves using historical costs of delivering similar services, where appropriate data are available, and determining the types and costs of products and services necessary to deliver services meeting federal and state requirements. The rates for transition assistance services are modeled using a pro forma approach.

Minor home modifications and adaptive aids are paid at cost.

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 consumer directed services agency, is a flat monthly fee determined by modeling the estimated cost to carry out the financial management responsibilities of the consumer directed services agency. The payment rate available for the individual's budget for the self-directed service is modeled based on the payment rate to the traditional agency less an adjustment for the traditional agency's indirect costs.

HHSC holds a public hearing before it approves rates. The purpose of the hearing is to give interested parties an opportunity to comment on the proposed rates. Notice of the hearing is provided to the public. The notice of the public hearing includes information about the proposed rate changes and identifies the name, address, and telephone number of the staff member to contact for the materials pertinent to the proposed rates. At least ten working days before the public hearing takes place, material pertinent to the proposed statewide uniform rates is made available to the public. The public may present comments at the hearing or submit written comments regarding the proposed rates. Information about payment rates is made available to individuals through HHSC and DADS websites as well as through the Texas Register via a public notice. Once rates are adopted, they are posted on the HHSC website and program providers are notified through an email generated by DADS.

- 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:

The services delivered through the agency option and the consumer directed services option, providers send claims for reimbursement for waiver services provided to individuals to State's contracted Medicaid Management Information Systems claims processing system. Providers may submit claims electronically or may submit paper claims.

## 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 the 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.**
- 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: *Complete item I-3-e.*

## 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 OHCD; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCD; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCD arrangement is employed, including the selection of providers not affiliated with the OHCD; (d) the method(s) for assuring that providers that furnish services under contract with an OHCD meet applicable provider qualifications under the waiver; (e) how it is assured that OHCD contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCD 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) (MCO) 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 State share to draw down the federal funds is appropriated to DADS for the MDCP program. The non-federal share of MDCP waiver program funds are appropriated by the Texas State Legislature to the DADS, the department designated by the HHSC, the single State Medicaid Agency, as the Medicaid operating agency for the MDCP 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. MDCP waiver non-federal share funds are appropriated to DADS as a specific line item for the provision of MDCP waiver services. If another agency were designated to operate the MDCP waiver program, those funds would be removed from DADS and appropriated to that agency. DADS MDCP waiver program appropriations remain in the state comptrollers account designated for the MDCP

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 of room and board is the responsibility of the individual except when room and board is provided under the waiver as part of out-of-home respite services. The rates for respite provided in the individual's home do not include room and board by design. Respite in all other settings is out-of-home respite and the room and board costs do not need to be excluded from these rates.

## 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-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

**Level(s) of Care: Hospital, Nursing Facility**

Col. 1 Year	Col. 2 Factor D	Col. 3 Factor D'	Col. 4 Total: D+D'	Col. 5 Factor G	Col. 6 Factor G'	Col. 7 Total: G+G'	Col. 8 Difference (Col 7 less Column4)
1	15143.16	58338.99	73482.15	41236.86	42589.72	83826.58	10344.43
2	15448.66	60257.00	75705.66	42020.36	43977.59	85997.95	10292.29
3	15759.27	62206.31	77965.58	42860.77	45425.73	88286.50	10320.92
4	16078.23	64246.33	80324.56	43675.12	46889.95	90565.07	10240.51
5	16369.07	66339.02	82708.09	44461.27	48435.42	92896.69	10188.60

## 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 Number Unduplicated Number of Participants (from	Distribution of Unduplicated Participants by Level of Care (if applicable)

	Item B-3-a)	Level of Care:	
		Hospital	Nursing Facility
Year 1	6901	690	6211
Year 2	7175	718	6457
Year 3	7450	745	6705
Year 4	7724	772	6952
Year 5	7999	800	7199

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (2 of 9)

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The State assumed that the new slots added each year will be added on a straight-line basis. Based upon this assumption, DADS is able to calculate the average number of individuals served per month for each year, as well as the number of individuals that will be served at the end of each year.

In addition, DADS calculated an historical average turnover rate of 1.2 percent per month from data for waiver year September 2010-August 2011. Based upon this rate, DADS calculated the number of individuals that will be added each year to replace those individuals exiting the program due to attrition by multiplying the average number of individuals served per month times the average attrition rate times 12 months.

The annual unduplicated number of individuals served each year is the sum of the individuals at the end of the year plus the individuals added, either by coming off of the Interest list or through  Money Follows the Person' Initiative, during the year to replace attrition. The annual number of service months was calculated by multiplying the average individuals served per month times 12 months. The average length-of-stay was derived by dividing the annual number of service months by the unduplicated individual count. In the following, the word "client" is used interchangeably with "individual."

% Monthly turnover (Sept 12-Aug 13) (Sept 13-Aug 14) (Sept 14-Aug 15) (Sept 15-Aug 16) (Sept 16-Aug 17)  
Distribution Rate Year 1 Year 2 Year 3 Year 4 Year 5

Average "base" clients per month 2380 2380 2380 2380 2380  
Average CWP conversion 24 24 24 24 24  
Average "Rider 18" Clients per month 3518 3758 3998 4238 4478  
Average Total Clients per month 5922 6162 6402 6642 6882

Base clients-end of year (EOY) 2380 2380 2380 2380 2380  
CWP clients EOY 24 24 24 24 24  
Rider clients EOY 3628 3868 4108 4348 4588  
Total clients at end of year 6032 6272 6512 6752 6992

Avg clients/month 1 5922 6162 6402 6642 6882  
Est End of Year (EOY) clients/month 6032 6272 6512 6752 6992  
Clients added during year 0.012 869 903 938 972 1007

Annual Unduplicated Clients 6901 7175 7450 7724 7999  
(EOY + clients added)

Total Client Months 71064 73944 76824 79704 82584

Length of stay (months) 10.3 10.31 10.31 10.32 10.32

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The utilization, units of service and costs per unit of service estimates were based upon claims data experience as well as the CMS 372 for the MDCP waiver for Fiscal Year 2010. For services where the state sets a per unit rate, assumed Personal Consumption Expenditure (PCE)  General  chained price deflators of: 0 percent for FY 2013, 1.9 percent for FY 2014, 2.0 percent for FY 2015, 1.9 percent for FY 2016, 2.0 percent for FY 2017. For services where the state does not set a per-unit rate, assumed PCE  Health Consumption  price deflators of: 2.8 percent for FY 2013, 2.9 percent for FY 2014, 3.0 percent for FY 2015, 3.0 percent for FY 2016, and 3.0 percent for FY 2017.

- 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 CMS 372 report for the MDCP waiver for FY 2010. For non-drug expenditures, assumed PCE  Health Consumption  price deflators of: 2.8 percent for FY 2013, 2.9 percent for FY 2017. For drug expenditures, assumed PCE  Pharma and other medical products  price deflators of: 12 percent for FY 2013 (inflated from FY 2010 to FY 2013), 5.4 percent for FY 2014, 5.0 percent for FY 2015, 4.5 percent for FY 2016, and 5.0 percent for FY 2017.

- 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. At the time that the data used to prepare the MDCP CMS 372 report for FY 2010 was run, the State also collected the claims payment data needed to calculate the G value for FY 2010. For FY 2013, assumed inflation of 1 percent (FY 2012 to FY 2013), which was the increase in the average monthly cost per Medicaid eligible individual in nursing facilities from FY 2012 to FY 2013. Assumed Personal Consumption Expenditure (PCE)  General  chained price deflators of: 1.9 percent for FY 2014, 2.0 percent for FY 2015, 1.9 percent for FY 2016, 2.0 percent for FY 2017.

- 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. At the time that the data used to prepare the MDCP CMS 372 report for FY 2010 was run, the State also collected the claims payment data needed to calculate the G value for FY 2010. For non-drug expenditures, assumed PCE  Health Consumption  price deflators of: 2.8 percent for FY 2013, 2.9 percent for FY 2014, 3.0 percent for FY 2015, 3.0 percent for FY 2016, and 3.0 percent for FY 2017. For drug expenditures, assumed PCE  Pharma and other medical products  price deflators of: 12 percent for FY 2013 (inflated from FY 2010 to FY 2013), 5.4 percent for FY 2014, 5.0 percent for FY 2015, 4.5 percent for FY 2016, and 5.0 percent for FY 2017.

## 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	
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<b>Respite</b>
<b>Financial Management Services</b>
<b>Adaptive Aids</b>
<b>Flexible Family Support Services</b>
<b>Minor Home Modifications</b>
<b>Transition Assistance Services</b>

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (5 of 9)**

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 1**

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Respite Total:</b>						<b>97482022.47</b>
Respite	per hour	4449	987.00	15.01	65911356.63	
Respite - Consumer Directed	per hour	2406	1143.00	11.48	31570665.84	
<b>Financial Management Services Total:</b>						<b>4374108.00</b>
Financial Management Services	per month	2406	9.00	202.00	4374108.00	
<b>Adaptive Aids Total:</b>						<b>356169.04</b>
Adaptive Aids	per item	136	1.00	2618.89	356169.04	
<b>Flexible Family Support Services Total:</b>						<b>1167140.00</b>
Flexible Family Support Services	per hour	130	670.00	13.40	1167140.00	
<b>Minor Home Modifications Total:</b>						<b>1107299.68</b>
Minor Home Modifications	per item	166	1.00	6670.48	1107299.68	
<b>Transition Assistance Services Total:</b>						<b>16200.00</b>
Transition Assistance Services	per item	9	1.00	1800.00	16200.00	
<b>GRAND TOTAL:</b>						<b>104502939.19</b>
Total Estimated Unduplicated Participants:						<b>6901</b>
Factor D (Divide total by number of participants):						<b>15143.16</b>
Average Length of Stay on the Waiver:						<b>259</b>

**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
<b>Respite Total:</b>						<b>103403851.20</b>
Respite	per hour	4626	988.00	15.30	69928466.40	
Respite - Consumer Directed	per hour	2501	1144.00	11.70	33475384.80	
<b>Financial Management Services Total:</b>						<b>4633252.56</b>
Financial Management Services	per month	2501	9.00	205.84	4633252.56	
<b>Adaptive Aids Total:</b>						<b>379972.44</b>
Adaptive Aids	per item	141	1.00	2694.84	379972.44	
<b>Flexible Family Support Services Total:</b>						<b>1234642.50</b>
Flexible Family Support Services	per hour	135	670.00	13.65	1234642.50	
<b>Minor Home Modifications Total:</b>						<b>1175919.06</b>
Minor Home Modifications	per item	173	1.00	6797.22	1175919.06	
<b>Transition Assistance Services Total:</b>						<b>16507.80</b>
Transition Assistance Services	per item	9	1.00	1834.20	16507.80	
<b>GRAND TOTAL:</b>						<b>110844145.56</b>
Total Estimated Unduplicated Participants:						7175
Factor D (Divide total by number of participants):						15448.66
Average Length of Stay on the Waiver:						266

## 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
<b>Respite Total:</b>						<b>109518780.28</b>
Respite	per hour	4803	988.00	15.61	74075132.04	
Respite - Consumer Directed	per hour	2597	1144.00	11.93	35443648.24	

<b>Financial Management Services Total:</b>						4907395.08
Financial Management Services	per month	2597	9.00	209.96	4907395.08	
<b>Adaptive Aids Total:</b>						408026.43
Adaptive Aids	per item	147	1.00	2775.69	408026.43	
<b>Flexible Family Support Services Total:</b>						1305696.00
Flexible Family Support Services	per hour	140	670.00	13.92	1305696.00	
<b>Minor Home Modifications Total:</b>						1247968.80
Minor Home Modifications	per item	180	1.00	6933.16	1247968.80	
<b>Transition Assistance Services Total:</b>						18708.80
Transition Assistance Services	per item	10	1.00	1870.88	18708.80	
<b>GRAND TOTAL:</b>						117406575.39
Total Estimated Unduplicated Participants:						7450
Factor D (Divide total by number of participants):						15759.27
Average Length of Stay on the Waiver:						287

## 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
<b>Respite Total:</b>						115855427.80
Respite	per hour	4980	989.00	15.91	78360250.20	
Respite - Consumer Directed	per hour	2693	1145.00	12.16	37495177.60	
<b>Financial Management Services Total:</b>						5185506.15
Financial Management Services	per month	2693	9.00	213.95	5185506.15	
<b>Adaptive Aids Total:</b>						434561.92
Adaptive Aids	per item	152	1.00	2858.96	434561.92	
<b>Flexible Family Support Services Total:</b>						1379643.10
Flexible Family Support Services	per hour	145	671.00	14.18	1379643.10	
<b>Minor Home Modifications Total:</b>						1314069.54

Minor Home Modifications	per item	186	1.00	7064.89	1314069.54	
<b>Transition Assistance Services Total:</b>						<b>19064.30</b>
Transition Assistance Services	per item	10	1.00	1906.43	19064.30	
<b>GRAND TOTAL:</b>						124188272.81
Total Estimated Unduplicated Participants:						7724
Factor D (Divide total by number of participants):						16078.23
Average Length of Stay on the Waiver:						287

## 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
<b>Respite Total:</b>						<b>122144601.40</b>
Respite	per hour	5157	989.00	16.20	82624422.60	
Respite - Consumer Directed	per hour	2788	1145.00	12.38	39520178.80	
<b>Financial Management Services Total:</b>						<b>5465037.60</b>
Financial Management Services	per month	2788	9.00	217.80	5465037.60	
<b>Adaptive Aids Total:</b>						<b>465719.22</b>
Adaptive Aids	per item	158	1.00	2947.59	465719.22	
<b>Flexible Family Support Services Total:</b>						<b>1453386.00</b>
Flexible Family Support Services	per hour	150	671.00	14.44	1453386.00	
<b>Minor Home Modifications Total:</b>						<b>1388067.58</b>
Minor Home Modifications	per item	193	1.00	7192.06	1388067.58	
<b>Transition Assistance Services Total:</b>						<b>19407.50</b>
Transition Assistance Services	per item	10	1.00	1940.75	19407.50	
<b>GRAND TOTAL:</b>						130936219.30
Total Estimated Unduplicated Participants:						7999
Factor D (Divide total by number of participants):						16369.07
Average Length of Stay on the Waiver:						298