



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

Andrew Fredrickson.
Associate Regional Administrator

1301 Young Street, Room 833
Dallas, Texas 75202
Phone (214) 767-6385
Fax (214) 767-0322

February 26, 2007

Our Reference: WA-TX0403.90

Chris Traylor
Associate Commissioner for Medicaid/SCHIP
Health and Human Services Commission
P. O. Box 13247
Austin, Texas 78711

Dear Mr. Traylor:

I am pleased to inform you that your request to renew your Medicaid Home and Community-Based Services waiver (HCBSW) No. 0403.90 has been approved. As authorized by Section 1915 (c) of the Social Security Act, this HCBSW program (Texas Home Living) provides an array of home and community-based services as an alternative to institutionalization in an Intermediate Care Facility for Persons with Mental Retardation and Related Conditions (ICF/MR). This renewal has been assigned control number 0403.90 which should be used in all future correspondence.

Specifically, you submitted a request to provide community support, day habilitation, employment assistance, supported employment, respite, nursing, behavioral support, occupational therapy, physical therapy, speech and language pathology, audiology, dietary, dental, adaptive aids, minor home modifications, financial management, support consultation and prescription drugs. The State has also indicated that recipients will be able to consumer-direct all waiver services with the exception of Financial Management Services and Prescription Drugs.

Thus, based on the assurances and information that you provided and the State's concurrence to the above listed requests, I approve the renewal request cited for a five-year period effective March 1, 2007. This approval is also subject to your agreement to serve no more individuals than indicated on your Factor "C" in your approved per capita expenditure estimate. The values for Factor "C" include any individuals replaced due to death or loss of eligibility for Medicaid services during the five years of the waiver program.

Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.3

Submitted by:

Texas Health and Human Services Commission
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Submission Date:	11/27/06
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CMS Receipt Date (CMS Use)	
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Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:

The State of Texas is requesting renewal of the Texas Home Living Program (TxHmL) waiver #0403.2, a Medicaid home and community-based services waiver under the authority of §1915(c) of the Social Security Act.

State:	TEXAS #403
Effective Date	March 1, 2007

**Texas Home Living
Waiver Renewal
03/01/2007 – 02/28/2012**

Table of Contents

General Description of Waiver Program	1
Request Information	
Brief Waiver Description	
Attachment 1: Components of the Waiver Request	
Waiver Requested	
Assurances	
Additional Requirements	
Contact Person(s)	
Authorizing Signature	
Appendix A – Waiver Administration and Operation	A:1
Appendix B – Participant Access and Eligibility	B-1:1
Appendix B-1 – Specification of the Waiver Target Group(s)	
Appendix B-2 – Individual Cost Limit	B-2:1
Appendix B-3 – Number of Individuals Served	B-3:1
Appendix B-4 – Medicaid Eligibility Groups Served in the Waiver	B-4:1
Appendix B-6 – Evaluation/Reevaluation of Level of Care	B-6:1
Appendix B-7 – Freedom of Choice	B-7:1
Appendix B-8 – Access to Services by Limited English Proficient Persons	B-8:1
Appendix C – Participant Services	C-1:1
Appendix C-1 – Summary of Services Covered	
Appendix C-2 – General Service Specifications	C-2:1
Appendix C-3 – Waiver Services Specifications	C-3:1
Appendix C-4 – Additional Limits on Amount of Waiver Services	C-4:1
Appendix D – Participant-Centered Planning and Service Delivery	D-1:1
Appendix D-1 – Service Plan Development	
Appendix D-2 – Service Plan Implementation and Monitoring	D-2:1
Appendix E – Participant Direction of Services	E-1:1
Appendix E-1 – Overview	
Appendix E-2 – Opportunities for Participant-Direction	E-2:1
Appendix F – Participant Rights	F-1:1
Appendix F-1 – Opportunity to Request a Fair Hearing	
Appendix F-2 – Additional Dispute Resolution Process	F-2:1

Appendix F-3 – State Grievance/Complaint System	F-3:1
Appendix G – Participant Safeguards	G-1:1
Appendix G-1 – Response to Critical Events or Incidents	
Appendix G-2 – Safeguards Concerning Restraints and Restrictive Interventions	G-2:1
Appendix G-3: Medication Management and Administration	G-3:1
Appendix H – Quality Management Strategy	H:1
Appendix I – Financial Accountability	I-1:1
Appendix I-1 – Financial Integrity and Accountability	
Appendix I-2 – Rates, Billing and Claims	I-2:1
Appendix I-3 – Payment	I-3:1
Appendix I-4 – Non-Federal Matching Funds	I-4:1
Appendix I-5 – Exclusion of Medicaid Payment for Room and Board	I-5:1
Appendix I-6 – Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver	I-6:1
Appendix I-7 – Participant Co-Payments for Waiver Services and Other Cost Sharing	J-1:1
Appendix J – Cost Neutrality Demonstration	J-1:3
Appendix J-1 – Composite Overview and Demonstration Of Cost Neutrality Formula	
Appendix J-2 – Derivation of Estimates	J-2:4

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

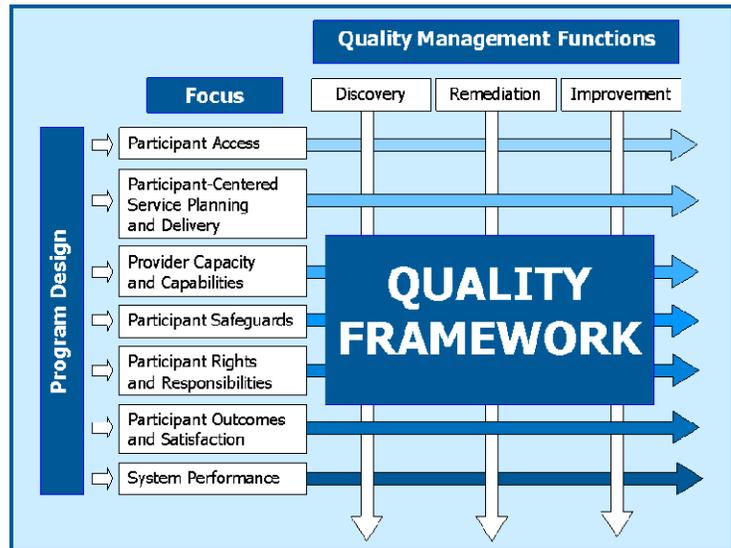
The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other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

The waiver application is based on the HCBS Quality Framework. The Framework focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services, including assuring participant health and welfare:

- ◆ **Participant Access:** *Individuals have access to home and community-based services and supports in their communities.*
- ◆ **Participant-Centered Service Planning and Delivery:** *Services and supports are planned and effectively implemented in accordance with each participant’s unique needs, expressed preferences and decisions concerning his/her life in the community.*
- ◆ **Provider Capacity and Capabilities:** *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
- ◆ **Participant Safeguards:** *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
- ◆ **Participant Rights and Responsibilities:** *Participants receive support to exercise their rights and in accepting personal responsibilities.*
- ◆ **Participant Outcomes and Satisfaction:** *Participants are satisfied with their services and achieve desired outcomes.*
- ◆ **System Performance:** *The system supports participants efficiently and effectively and constantly strives to improve quality.*

The Framework also stresses the importance of respecting the preferences and autonomy of waiver participants.

The Framework embodies the essential elements for assuring and improving the quality of waiver services: design, discovery, remediation and improvement. The State has flexibility in developing and implementing a Quality Management Strategy to promote the achievement of the desired outcomes expressed in the Quality Framework.



State:	TEXAS # 0403
Effective Date	March 1, 2007

1. Request Information

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. **Waiver Title (optional):** **Texas Home Living**

C. **Type of Request (select only one):**

<input type="radio"/>	New Waiver (3 Years)	CMS-Assigned Waiver Number (<i>CMS Use</i>):	
<input type="radio"/>	New Waiver (3 Years) to Replace Waiver #		
	CMS-Assigned Waiver Number (<i>CMS Use</i>):		
	<i>Attachment #1 contains the transition plan to the new waiver.</i>		
<input checked="" type="radio"/>	Renewal (5 Years) of Waiver #	0403.02	
<input type="radio"/>	Amendment to Waiver #		

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

<input type="radio"/>	Model Waiver. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
<input checked="" type="radio"/>	Regular Waiver , as provided in 42 CFR §441.305(a)

E.1 **Proposed Effective Date:** **March 1, 2007**

E.2 **Approved Effective Date (CMS Use):** _____

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*):

<input type="checkbox"/>	Hospital (select applicable level of care)
<input type="radio"/>	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:
<input type="radio"/>	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
<input type="checkbox"/>	Nursing Facility (select applicable level of care)
<input type="radio"/>	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:
<input type="radio"/>	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
<input checked="" type="radio"/>	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 facility level of care:
	The waiver is limited to ICF/MR Level of Care I.

State:	TEXAS # 0403
Effective Date	March 1, 2007

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

<input type="checkbox"/>	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I		
<input type="checkbox"/>	Waiver(s) authorized under §1915(b) of the Act. <i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i>		
Specify the §1915(b) authorities under which this program operates (<i>check each that applies</i>):			
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input type="checkbox"/>	§1915(b)(3) (employ cost savings to furnish additional services)
<input type="checkbox"/>	§1915(b)(2) (central broker)	<input type="checkbox"/>	§1915(b)(4) (selective contracting/limit number of providers)
<input type="checkbox"/>	A program authorized under §1115 of the Act. <i>Specify the program:</i>		
<input checked="" type="checkbox"/>	Not applicable		

State:	TEXAS # 0403
Effective Date	March 1, 2007

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 Texas Home Living Program (TxHmL), first authorized March 1, 2004, provides essential community-based services and supports to individuals with mental retardation living in their own homes or with their families. Services and supports are intended to enhance quality of life, functional independence, and health and well being in continued community-based living in their own or family home and to enhance, rather than replace, existing informal or formal supports and resources. TxHmL makes all service components available through both the participant direction option and the traditional service delivery option. Participants choose which services will be delivered through either service delivery option. Individuals enrolling in the waiver are assisted by a service coordinator (case manager) employed by one of the state's 40 local mental retardation authorities (MRAs). Service coordination for individuals enrolled in the TxHmL Program is funded through the state's Targeted Case Management Program. The MRA serving the geographic area in which the individual lives provides initial and on-going service coordination in accordance with its Performance Contract with the Texas Department of Aging and Disability Services (DADS), and with DADS rules governing the program. The service coordinator, using a person-directed planning process, is responsible for: facilitating an individual's enrollment; coordinating the development of the individual's service plan; informing the individual of the service delivery options (participant direction option or traditional agency option) for the services in the plan; assisting the individual in accessing non-waiver services; and for on-going monitoring of the provision of services and effectiveness of the service plan. The process emphasizes the provision of supports and services necessary to maintain successful integration in the community and to acquire skills necessary for participation in activities that are personally important. The service plan describes the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All waiver services will be furnished pursuant to this written service plan.

The single State Medicaid agency, the Texas Health and Human Service Commission (HHSC), exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. HHSC directly performs financial eligibility determinations for prospective enrollees; develops the reimbursement rate methodology and sets reimbursement rates; and conducts Medicaid Fair Hearings in accordance with 42 CFR §431 Subpart E, and as described in 1 Texas Administrative Code (TAC) Part 15, Chapter 357 Subchapter A (relating to Medicaid Fair Hearings).

HHSC delegates routine functions necessary to the operation of the waiver to the operating agency, the Texas Department of Aging and Disability Services (DADS). These functions include managing waiver enrollment against approved limits; monitoring waiver expenditures against approved levels; conducting level of care evaluation activities and authorizing levels of care; reviewing individual service plans to ensure that waiver requirements are met; conducting utilization management and waiver service authorization functions; enrolling providers and executing the Medicaid provider agreements; conducting training and technical assistance concerning waiver requirements; and performing quality management functions.

State:	TEXAS # 0403
Effective Date	March 1, 2007

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

<input checked="" type="checkbox"/>	The waiver provides for participant direction of services. <i>Appendix E is required.</i>
<input type="checkbox"/>	Not applicable. The waiver does not provide for participant direction of services. <i>Appendix E is not completed.</i>

- 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 Management Strategy.** Appendix H contains the Quality Management Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State’s demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

<input type="checkbox"/>	Yes
<input checked="" type="checkbox"/>	No
<input type="checkbox"/>	Not applicable

State:	TEXAS 0403
Effective Date	January 1, 2007

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

<input type="radio"/>	Yes (<i>complete remainder of item</i>)
<input checked="" type="radio"/>	No

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

<input type="checkbox"/>	Geographic Limitation. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. <i>Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:</i>
<input type="checkbox"/>	Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to make <i>participant direction of services</i> 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. <i>Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:</i>

5. Assurances

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

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
 1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

State:	TEXAS 0403
Effective Date	January 1, 2007

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 Improvement Act of 2004 (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) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration 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.

State:	TEXAS 0403
Effective Date	January 1, 2007

- 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 §431.51, 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 Management.** 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 Management Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:

The State regularly conducts focus groups, especially in evaluating current stakeholder experience, evolving needs, model design, barriers to participation, and new initiatives. In addition, communications with advocate groups are ongoing.

The State also assures multiple opportunities for stakeholder and public comment in the formal rule promulgation process. HHSC facilitates the State’s Consumer Directed Services Workgroup, which regularly convenes to discuss and recommend improvements in the CDS option offered through DADS community-based programs.

- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State’s intent to submit a Medicaid waiver request or renewal request to CMS at least 60

State:	TEXAS 0403
Effective Date	January 1, 2007

days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

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

7. Contact Person(s)

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

First Name:	Betsy
Last Name	Johnson
Title:	Policy Analyst
Agency:	Texas Health and Human Services Commission
Address 1:	11209 Metric Blvd H-620
Address 2:	
City	Austin
State	TX
Zip Code	78758
Telephone:	512-491-1199
E-mail	betsy.johnson@hhsc.state.tx.us
Fax Number	512-491-1953

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

First Name:	Beverly
Last Name	Sawyer
Title:	Manager III
Agency:	Texas Department of Aging and Disability Services
Address 1:	701 West 51 st Street
Address 2	P.O. Box 149030
City	Austin
State	TX
Zip Code	78714-9030
Telephone:	512-438-3530
E-mail	beverly.sawyer@dads.state.tx.us
Fax Number	512-438-3314

State:	TEXAS 0403
Effective Date	January 1, 2007

8. Authorizing Signature

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.

Signature: _____ **Date:** _____
 State Medicaid Director

First Name:	Chris
Last Name	Traylor
Title:	State Medicaid Director
Agency:	Texas Health and Human Services Commission
Address 1:	P.O. Box 13247
Address 2:	
City	Austin
State	TX
Zip Code	78711
Telephone:	512-491-1463
E-mail	chris.traylor@hhsc.state.tx.us
Fax Number	512-491-1977

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not Applicable

State:	TEXAS 0403
Effective Date	January 1, 2007

Appendix A: Waiver Administration and Operation

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

<input type="radio"/>	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 (<i>select one; do not complete Item A-2</i>):
<input type="radio"/>	The Medical Assistance Unit (<i>name of unit</i>):
<input type="radio"/>	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (<i>name of division/unit</i>):
<input checked="" type="radio"/>	The waiver is operated by The Texas Department of Aging and Disability Services a separate agency of the State that is not a division/unit of the Medicaid agency. 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. <i>Complete item A-2.</i>

2. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, 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 accordance with 42 CFR §431.10 (e), HHSC is the single state Medicaid agency and retains administrative authority over the waiver program.

Structural and Organizational Responsibilities

The Texas Department of Aging and Disability Services (“DADS”) is the designated operating agency for this waiver. The Long Term Care (LTC) Policy Unit of the State Medicaid Director's Office is directly responsible for monitoring and oversight. At the direction of HHSC, DADS may develop proposed state rules governing the TxHmL Program for subsequent final adoption by HHCS or proposed amendments for waiver programs with final approval by HHSC. The LTC Policy Unit is responsible for approving all waivers and the CMS-372(S) reports. In addition, the LTC Policy Unit reviews all waiver program policies and operations and may require DADS staff to modify, clarify, or provide additional information in considering approval or disapproval of proposed changes.

Oversight Methods and Activities

HHSC’s oversight of waiver activities goes beyond the statutory requirement of retaining administrative authority over the waiver and is being expanded further in accordance with the CMS HCBS quality assurance guidelines. This expansion is incremental and formative; however; HHSC Medicaid LTC staff is scheduling and conducting on-site visits to provider agencies and will be monitoring DADS’ provider reviews. Additionally, HHSC Medicaid LTC staff is actively involved in program design changes such as the implementation of consumer direction options and in the development of quality assurance activities. HHSC leads the state’s Consumer Direction Task Force and monitors DADS implementation of consumer direction

State:	TEXAS 0403
Effective Date	March 1, 2007

activities on an ongoing basis through quarterly meetings and annual reports.

HHSC Medicaid LTC staff is actively involved in the development of quality assurance activities at DADS. In September 2004, HHSC staff convened a meeting of senior staff at DADS to initiate base-lining and evaluation activities related to the new CMS waiver guidelines. At that meeting, HHSC staff presented the new CMS guidelines and related quality assurance information along with the direction that the operating agency review the new requirements and develop strategies to accomplish the required results. Since that time, HHSC and DADS staff has held 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 to the Medicaid agency; base-line current activities using the CMS sponsored waiver review matrix developed by the Muskie School of Public Service; initiate joint on-site reviews of program providers; and evaluate the development of a quality management strategy that spans more than one waiver and potentially other types of long-term care services.

HHSC's involvement and oversight in the development of enhanced waiver quality assurance mechanisms under the new CMS guidelines will assure continued development of HHSC oversight of all areas of waiver operations, as outlined below.

Disseminate information concerning the waiver to potential enrollees and assist individuals in waiver enrollment:

Texas uses a single point of access for mental retardation services. This is accomplished through performance contracts with local agencies called "Mental Retardation Authorities" (MRAs). As delegated by HHCS to DADS, MRAs contract with DADS to provide for the dissemination of information about mental retardation services, including waiver services. MRAs assist individuals enrolling into the TxHmL Program as well as other state mental retardation services.

Manage waiver enrollment against approved limits and monitor waiver expenditures against approved levels:

Enrollment limits are approved by HHSC during the initial, renewal, and waiver amendment processes as cost neutrality calculations are adjusted. DADS is responsible for monitoring waiver enrollment within the established calculations and funding levels. Enrollment generally remains stable unless additional funds are made available by the Texas state legislature. When this recently happened, HHSC requested ad hoc reports on progress with the roll-out of new waiver slots.

Conduct level of care evaluation activities; review participant service plans to ensure that waiver requirements are met; perform prior authorization of waiver services; and conduct utilization management functions:

For level of care, service plan, and prior authorization, DADS, with HHCS concurrence, has implemented automated processes that reject processing or payment through business edits when programmatic requirements for services and items approved by HHSC are not met or are not in place. Providers are required to maintain this information on-site for inspection during on-site reviews by DADS's monitoring staff.

In accordance with CMS quality framework guidelines, DADS has developed quality indicators related to these items. These new indicators were first reported to HHSC during the development of the Evidentiary Report to CMS for this waiver. The indicators will be reported to HHSC on an annual basis going forward as our new quality system is developed and enhanced.

State:	TEXAS 0403
Effective Date	March 1, 2007

Conduct utilization management functions:
 Reported to HHSC under new indicators.

Recruit providers:
HHSC approves and adopts rules governing the recruitment and enrollment of providers.

Execute the Medicaid provider agreement:
DADS uses a contract, which includes the requirements of the Medicaid Provider Agreement as binding on the provider. The contract exceeds the Medicaid requirements and covers additionally required State stipulations. DADS executes the provider agreement on behalf of HHSC, the Texas Single State Medicaid Agency.

Determine waiver payment amounts or rates:
HHCS performs this function.

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 the newly developed quality indicators. HHSC monitors DADS’ training using the quality indicators and reserves the right to discuss, review or suggest additional training topics for DADS providers.

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

<input type="checkbox"/>	Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. <i>Complete Items A-5 and A-6.</i>
<input checked="" type="checkbox"/>	No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

State:	TEXAS 0403
Effective Date	March 1, 2007

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 (*check each that applies*):

<input checked="" type="checkbox"/>	<p>Local/Regional non-state public agencies conduct waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these agencies and complete items A-5 and A-6:</i></p> <p>DADS holds performance contracts with local community centers, established in accordance with Texas Health and Safety Code, Chapter 534, and with a local Council of Government (COG), established in accordance with Texas Local Government Code, Chapter 391. These entities have been designated by DADS as Mental Retardation Authorities (MRA) in accordance with Texas Health and Safety Code, §533.035, and, as part of their responsibilities, disseminate information about the waiver to potential enrollees; assist individuals in waiver enrollment; assist in managing waiver enrollment; and conduct level of care evaluation activities.</p>
<input type="checkbox"/>	<p>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). <i>Specify the nature of these entities and complete items A-5 and A-6:</i></p>
<input type="checkbox"/>	<p>Not applicable – Local/regional non-state agencies do not perform waiver operational and administrative functions.</p>

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:

DADS is the state operating agency.

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:

<p>DADS conducts at least annual on-site reviews of a local Mental Retardation Authority’s (MRA) compliance with the TxHmL program principles for MRAs. Non-compliance with any of the TxHmL program principles for MRAs requires the submission of a plan of correction, which is monitored by DADS staff. Failure to fully implement a plan of correction authorized by DADS may result in financial penalties to the MRA.</p> <p>The 16 TxHmL MRA principles are outcome-based and contain requirements for personnel qualifications, participant choice, quality assurance, and health, welfare, and rights. On-site review activities include examination of service delivery records; evidence related to recipient choice, rights, health, and welfare; quality assurance systems; freedom from abuse, neglect, and exploitation; and verification of current levels of care (LOC), person-directed plans (PDP), and individual service plans. The on-site review also includes evaluation of the MRA’s process of notifying an individual of an offer of enrollment, advising the individual of services available through the waiver, and</p>

State:	TEXAS 0403
Effective Date	March 1, 2007

limitations of services; the MRA’s process for assuring objectivity in assisting an individual in provider selection; and that appropriate documentation is submitted to DADS in accordance with timeframes. The process emphasizes the provision of supports and services necessary to maintain successful integration in the community and to acquire skills necessary for participation in activities that are personally important. For any principle out of compliance at the end of an MRA review, the MRA must submit a plan of correction to DADS within 30 days of the exit date of the review. Deficiencies are addressed and corrected by on-site consultation; response to telephone and e-mail inquiries, review and approval of corrective action plans.

DADS reports the results of the MRA reviews annually to HHSC through the CMS 372 report.

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.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	<input type="checkbox"/>	X	<input type="checkbox"/>	X
Assist individuals in waiver enrollment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X
Manage waiver enrollment against approved limits	X	X	<input type="checkbox"/>	X
Monitor waiver expenditures against approved levels	X	X	<input type="checkbox"/>	<input type="checkbox"/>
Conduct level of care evaluation activities	X	X	<input type="checkbox"/>	X
Review participant service plans to ensure that waiver requirements are met	X	X	<input type="checkbox"/>	X
Perform prior authorization of waiver services	X	X	<input type="checkbox"/>	<input type="checkbox"/>
Conduct utilization management functions	X	X	<input type="checkbox"/>	<input type="checkbox"/>
Recruit providers	X	X	<input type="checkbox"/>	<input type="checkbox"/>
Execute the Medicaid provider agreement	X	X	<input type="checkbox"/>	<input type="checkbox"/>
Determine waiver payment amounts or rates	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct training and technical assistance concerning waiver requirements	X	X	<input type="checkbox"/>	<input type="checkbox"/>

State:	TEXAS 0403
Effective Date	March 1, 2007

Appendix B: Participant Access and Eligibility

Appendix 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. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup 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:*

INCLUDED	TARGET GROUP/SUBGROUP	MINIMUM AGE	MAXIMUM AGE	
			MAXIMUM AGE LIMIT: THROUGH AGE –	NO MAXIMUM AGE LIMIT
<input type="radio"/>	Aged or Disabled, or Both			
<input type="checkbox"/>	Aged (age 65 and older)			<input type="checkbox"/>
<input type="checkbox"/>	Disabled (Physical) (under age 65)			
<input type="checkbox"/>	Disabled (Other) (under age 65)			
Specific Aged/Disabled Subgroup				
<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input checked="" type="checkbox"/>	Mental Retardation or Developmental Disability, or Both			
<input type="checkbox"/>	Autism			<input type="checkbox"/>
<input checked="" type="checkbox"/>	Developmental Disability	0		<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Mental Retardation	0		<input checked="" type="checkbox"/>
<input type="radio"/>	Mental Illness			
<input type="checkbox"/>	Mental Illness (age 18 and older)			<input type="checkbox"/>
<input type="checkbox"/>	Serious Emotional Disturbance (under age 18)			

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

Eligible individuals: <ol style="list-style-type: none"> 1. Meet the Level of Care I criteria for Intermediate Care Facilities for Persons with Mental Retardation as specified in 40 Texas Administrative Code (TAC), Part 1, Chapter 9, Subchapter E and have had a determination of mental retardation performed in accordance with state law or have been diagnosed by a physician as having a related condition; 2. Qualify for a level of need assignment 1, 5, 6, or 8 as defined in 40 TAC, Part 1, Chapter 9, Subchapter N, Section 9.562; 3. Live in his or her own home or family's home; 4. Are not concurrently enrolled in another 1915(c) waiver program; and 5. Choose participation in the TxHmL Program over participation in the ICF/MR Program.
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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*):

State:	TEXAS 0403
Effective Date	March 1, 2007

Appendix B: Participant Access and Eligibility
HCBS Waiver Application Version 3.3 – October 2005

<input checked="" type="radio"/>	Not applicable – There is no maximum age limit
<input type="radio"/>	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (<i>specify</i>):

State:	TEXAS 0403
Effective Date	March 1, 2007

Appendix B-2: Individual Cost Limit

- 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*):

<input type="radio"/>	No Cost Limit. The State does not apply an individual cost limit. <i>Do not complete Item B-2-b or Item B-2-c.</i>		
<input type="radio"/>	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. <i>Complete Items B-2-b and B-2-c.</i> The limit specified by the State is (<i>select one</i>):		
<input type="radio"/>		%, a level higher than 100% of the institutional average	
<input type="radio"/>	Other (<i>specify</i>):		
<input type="radio"/>	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. <i>Complete Items B-2-b and B-2-c.</i>		
<input checked="" type="radio"/>	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. <i>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.</i>		
	This waiver is intended to serve persons who are currently eligible to receive Medicaid State Plan services and who can continue to live in their own or family homes if the supports of their informal networks are augmented with basic services and supports through the waiver. The TxHmL experience during the first two years of operation indicates that waiver service costs for these individuals average under \$5,000 per year. Given the history of the population's service utilization, a \$10,000 annual cost limit allows flexibility for their service needs.		
	The cost limit specified by the State is (<i>select one</i>):		
<input checked="" type="radio"/>	The following dollar amount: \$	10,000 annually	
	The dollar amount (<i>select one</i>):		
<input type="radio"/>	Is adjusted each year that the waiver is in effect by applying the following formula:		
<input checked="" type="radio"/>	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.		
<input type="radio"/>	The following percentage that is less than 100% of the institutional average:		%
<input type="radio"/>	Other – <i>Specify</i> :		

State:	TEXAS 0403
Effective Date	March 1, 2007

- 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 home and community-based service provided under this waiver is designed for individuals who need only essential services and supports to continue to reside in their own homes or in their family home. These individuals are also anticipated to have an established natural support system. The waiver is not intended to serve individuals requiring intensive supports (e.g., individuals requiring out-of-home residential services or intensive behavioral support).

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

An applicant or individual whose request for eligibility for the waiver program is denied or is not acted upon with reasonable promptness is entitled to a fair hearing in accordance 1 TAC **Part 15**, Chapter 357, Subchapter A. DADS must send written notification to the individual or legally authorized representative (LAR), indicating the individual's right to a fair hearing and the process to follow to request a fair hearing.

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

<input type="checkbox"/>	The participant is referred to another waiver that can accommodate the individual's needs.
<input type="checkbox"/>	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:

State:	TEXAS 0403
Effective Date	March 1, 2007

X	<p>Other safeguard(s) (<i>specify</i>):</p> <p>An individual will not lose eligibility for the waiver due to an increased need for a covered service that would cause the cost of the individual’s service plan to exceed the total service limit established by the state unless DADS has evaluated the individual’s needs and determined that the individual’s health and welfare cannot be assured by any one or combination of the following:</p> <ul style="list-style-type: none"> • Accessing additional assistance of family or local community organizations and other natural supports; • Authorizing an exception to the service category limits established by the State for this waiver program; or • Seeking funding through non-waiver resources such as State Medicaid Plan services, local Mental Retardation Authorities, or local community agencies. <p>To the extent that the above efforts are unsuccessful, and the State finds that the absence of sufficient service(s) prevents the State from assuring the individual’s health and welfare in the community, the following will apply:</p> <ul style="list-style-type: none"> • The individual will be given an opportunity to request services through another existing home and community-based service program for which the individual may be eligible; • The individual will be assisted in seeking admission to an ICF/MR, if appropriate; and • The individual will be informed of and given the opportunity to request a fair hearing in accordance with 1 TAC Part 15, Chapter 357, Subchapter A, if the State proposes to terminate the individual’s waiver eligibility.
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State:	TEXAS 0403
Effective Date	March 1, 2007

Appendix B-3: Number of Individuals Served

- 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	2,762
Year 2	3,074
Year 3	3,401
Year 4 (renewal only)	3,401
Year 5 (renewal only)	3,401

- 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)*:

<input checked="" type="checkbox"/>	The State does not limit the number of participants that it serves at any point in time during a waiver year.
<input type="checkbox"/>	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	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

State:	TEXAS 0403
Effective Date	March 1, 2007

- 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*):

<input type="radio"/>	Not applicable. The state does not reserve capacity.																								
<input checked="" type="radio"/>	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined: The State has reserved capacity for two target groups of individuals meeting the waiver eligibility criteria: (A) Individuals receiving state funded community-based mental retardation services through a local Mental Retardation Authority contracted with DADS and whose cost of service is approximately \$3,900 per year but less than \$9,999; (B) Individuals registered on the interest list for the Home and Community Based Services (HCS) Program (waiver # 0110) by a Mental Retardation Authority contracted with DADS. DADS does not maintain a separate interest list for the TxHmL Program. The State offers TxHmL Program vacancies to individuals in Group B on a “first-come, first-served” basis according to the chronological date of the individual’s registration on the HCS interest list.																								
	The capacity that the State reserves in each waiver year is specified in the following table:																								
Table B-3-c																									
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">Purpose:</td> <td style="text-align: center;">Purpose:</td> </tr> <tr> <td></td> <td style="text-align: center;">Group A</td> <td style="text-align: center;">Group B</td> </tr> <tr> <td style="text-align: center;">Waiver Year</td> <td style="text-align: center;">Capacity Reserved</td> <td style="text-align: center;">Capacity Reserved</td> </tr> <tr> <td style="text-align: center;">Year 1</td> <td style="text-align: center;">1,012</td> <td style="text-align: center;">1,873</td> </tr> <tr> <td style="text-align: center;">Year 2</td> <td style="text-align: center;">1,012</td> <td style="text-align: center;">1,873</td> </tr> <tr> <td style="text-align: center;">Year 3</td> <td style="text-align: center;">1,012</td> <td style="text-align: center;">1,873</td> </tr> <tr> <td style="text-align: center;">Year 4 (renewal only)</td> <td style="text-align: center;">1,012</td> <td style="text-align: center;">1,873</td> </tr> <tr> <td style="text-align: center;">Year 5 (renewal only)</td> <td style="text-align: center;">1,012</td> <td style="text-align: center;">1,873</td> </tr> </table>		Purpose:	Purpose:		Group A	Group B	Waiver Year	Capacity Reserved	Capacity Reserved	Year 1	1,012	1,873	Year 2	1,012	1,873	Year 3	1,012	1,873	Year 4 (renewal only)	1,012	1,873	Year 5 (renewal only)	1,012	1,873
	Purpose:	Purpose:																							
	Group A	Group B																							
Waiver Year	Capacity Reserved	Capacity Reserved																							
Year 1	1,012	1,873																							
Year 2	1,012	1,873																							
Year 3	1,012	1,873																							
Year 4 (renewal only)	1,012	1,873																							
Year 5 (renewal only)	1,012	1,873																							

- 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*):

<input checked="" type="radio"/>	The waiver is not subject to a phase-in or a phase-out schedule.
<input type="radio"/>	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 <i>intra-year</i> limitation on the number of participants who are served in the waiver.

- e. **Allocation of Waiver Capacity.** *Select one:*

State:	TEXAS 0403
Effective Date	March 1, 2007

Appendix B: Participant Access and Eligibility
 HCBS Waiver Application Version 3.3 – October 2005

<input checked="" type="radio"/>	Waiver capacity is allocated/managed on a statewide basis.
<input type="radio"/>	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:

A local MRA must maintain an up to date interest list of applicants living in the MRA’s local service area who are seeking services through the State’s Home and Community-based Services (HCS) Program (HCBSW # 0110) and must assign an applicant's placement on the interest list chronologically in accordance with 40 TAC Part 1, Chapter 9, Subchapter D. **DADS does not maintain a separate interest list for the TxHmL Program. The State offers vacancies to individuals in Group B on a “first-come, first-served” basis according to the chronological date of the individual’s registration on the HCS interest list.**

Upon written notification by DADS of a TxHmL Program vacancy in the MRA's local service area, the MRA notifies the applicant or LAR whose name is first on the interest list for the HCS Program as maintained by the MRA.

Individuals included in Group B are offered services under this waiver when the individual is receiving state funded community-based mental retardation services through a local Mental Retardation Authority and the cost of state funded services for that individual is approximately \$3,900 per year, but less than \$9,999.

State:	TEXAS 0403
Effective Date	March 1, 2007

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

a. The waiver is being (*select one*):

<input type="radio"/>	Phased-in
<input type="radio"/>	Phased-out

b. **Waiver Years Subject to Phase-In/Phase-Out Schedule** (*check each that applies*):

Year One	Year Two	Year Three	Year Four	Your Five
<input type="checkbox"/>				

c. **Phase-In/Phase-Out Time Period.** *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

d. **Phase-In or Phase-Out Schedule.** *Complete the following table:*

Phase-In or Phase-Out Schedule			
Waiver Year:			
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

State:	TEXAS 0403
Effective Date	March 1, 2007

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

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

<input checked="" type="checkbox"/>	§1634 State
<input type="checkbox"/>	SSI Criteria State
<input type="checkbox"/>	209(b) State

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:*

<i>Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)</i>					
<input checked="" type="checkbox"/>	Low income families with children as provided in §1931 of the Act				
<input checked="" type="checkbox"/>	SSI recipients				
<input type="checkbox"/>	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121				
<input type="checkbox"/>	Optional State supplement recipients				
<input type="checkbox"/>	Optional categorically needy aged and/or disabled individuals who have income at: (<i>select one</i>)				
<input type="checkbox"/>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;"><input type="checkbox"/></td> <td>100% of the Federal poverty level (FPL)</td> </tr> <tr> <td style="width: 20px; text-align: center;"><input type="checkbox"/></td> <td>% of FPL, which is lower than 100% of FPL</td> </tr> </table>	<input type="checkbox"/>	100% of the Federal poverty level (FPL)	<input type="checkbox"/>	% of FPL, which is lower than 100% of FPL
<input type="checkbox"/>	100% of the Federal poverty level (FPL)				
<input type="checkbox"/>	% of FPL, which is lower than 100% of FPL				
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)				
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)				
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)				
<input type="checkbox"/>	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)				
<input type="checkbox"/>	Medically needy				
<input checked="" type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify:</i>				
	All other categorically needy groups covered under the State Plan except for the special groups covered under 42 CFR 435.217, 435.211 and 435.236.				
<i>Special home and community-based waiver group under 42 CFR §435.217</i> Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed					
<input checked="" type="checkbox"/>	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.				
<input type="checkbox"/>	Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. <i>Select one and complete Appendix B-5.</i>				
<input type="checkbox"/>	All individuals in the special home and community-based waiver group under 42 CFR §435.217				

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix B: Participant Access and Eligibility
 HCBS Waiver Application Version 3.3 – October 2005

<input type="radio"/>	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 (<i>check each that applies</i>):		
	<input type="checkbox"/>	A special income level equal to (select one):	
		<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)
		<input type="radio"/>	% of FBR, which is lower than 300% (42 CFR §435.236)
		<input type="radio"/>	\$ which is lower than 300%
	<input type="checkbox"/>	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)	
	<input type="checkbox"/>	Medically needy without spend down in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)	
	<input type="checkbox"/>	Medically needy without spend down in 209(b) States (42 CFR §435.330)	
	<input type="checkbox"/>	Aged and disabled individuals who have income at: (<i>select one</i>)	
		<input type="radio"/>	100% of FPL
		<input type="radio"/>	% of FPL, which is lower than 100%
	<input type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify</i> :	

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix 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 waiver 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 (<i>insert number</i>):
		One
ii.	Frequency of services.	The State requires (<i>select one</i>):
	<input type="radio"/>	The provision of waiver services at least monthly
	<input checked="" type="radio"/>	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*):

<input type="radio"/>	Directly by the Medicaid agency
<input checked="" type="radio"/>	By the operating agency specified in Appendix A
<input type="radio"/>	By an entity under contract with the Medicaid agency. <i>Specify the entity:</i>
<input type="radio"/>	Other (<i>specify</i>):

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

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are: Registered Nurse licensed by the State, Licensed Social Worker, or Qualified Mental Retardation Professional as defined in 42 CFR 483.430(a).
--

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

State:	TEXAS #0403
Effective Date	March 1, 2007

The required ICF/MR Level of Care I is defined in 40 TAC **Part 1**, Chapter 9, Subchapter E, (relating to ICF/MR Programs) as follows:

(A) To meet the LOC I criteria, a person must:

(1) Meet the following criteria:

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

(b) Have a full scale IQ score of 75 or below, obtained by administering a standardized individual intelligence test, and have a primary diagnosis by a licensed physician of a related condition that is included on the DADS Approved Diagnostic Codes for Persons with Related Conditions.

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

(B) If a person has a sensory or motor deficit for which a specially standardized intelligence test or a certain portion of a standardized intelligence test is appropriate, the appropriate score should be used.

(C) If a full-scale IQ score cannot be obtained from a standardized intelligence test due to age, functioning level, or other severe limitations, an estimate of a person's intellectual functioning should be documented with clinical justification.

The Level of Care is assigned based on information submitted electronically by the MRA providing service coordination to the individual via the Client Assignment and Registration System (CARE) utilizing the Mental Retardation/Related Condition (MR./RC) Assessment. The MR/RC Assessment includes all factors that are assessed in evaluating a level of care determination: diagnostic information that includes age of onset of the condition, results of standardized intelligence testing and assessments of adaptive behavior; measures from the Inventory for Client and Agency Planning (ICAP), behavioral status and information regarding day services.

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*):

<input checked="" type="radio"/>	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
<input type="radio"/>	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 local MRA completes the Mental Retardation/Related Condition (MR/RC) Assessment and requests an LOC determination for an applicant or annually for an enrolled individual by electronically submitting the initial or renewal MR/RC Assessment, via the Client Assignment and Registration System (CARE) system, indicating the recommended LOC. The process for evaluation and reevaluation are the same.

An LOC determination must be made by DADS in accordance with criteria specified in Section D of this Appendix, and is assigned based on information submitted electronically via the CARE system utilizing the MR/RC Assessment. Information on the MR/RC Assessment must be supported by current data obtained from standardized evaluations and formal assessments that measure physical, emotional, social, and cognitive factors.

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix B: Participant Access and Eligibility
 HCBS Waiver Application Version 3.3 – October 2005

The MRA must maintain the signed MR/RC Assessment and documentation supporting the recommended LOC in the applicant's or individual's record. The electronically transmitted MR/RC Assessment must contain information identical to that on the signed MR/RC Assessment.

DADS must approve and enter the appropriate LOC into the CARE system or send written notification to the service coordinator that an LOC has been denied. An LOC determination is valid for 364 calendar days after the LOC effective date determined by the department.

- 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*):

<input type="radio"/>	Every three months
<input type="radio"/>	Every six months
<input checked="" type="radio"/>	Every twelve months
<input type="radio"/>	Other schedule (<i>specify</i>):

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

<input checked="" type="radio"/>	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
<input type="radio"/>	The qualifications are different. The qualifications of individuals who perform reevaluations are (<i>specify</i>):

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

The State employs the following procedures to ensure timely reevaluations of level of care:
 1. Edits in the automated Client Assignment Registration and Enrollment (CARE) system; and
 2. Annual review of MRAs to determine that reevaluations occur timely.

- 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 §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records of evaluations and re-evaluations of level of care are maintained in the following locations:
 DADS, the operating agency; MRAs, and TxHmL program providers.

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix B-7: Freedom of Choice

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

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

A local MRA service coordinator informs applicants of services available under the waiver. The service coordinator presents the applicant with program information for both the home and community-based services waiver program and the Intermediate Care Facilities for Persons with Mental Retardation or Related Conditions. Following the presentation of this information, the service coordinator offers the applicant the opportunity to make an informed choice between these programs and documents the applicant's decision to accept or refuse the home and community-based services on the Freedom of Choice Verification Form.

- b. **Maintenance of Forms.** Per 45 CFR §74.53, 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 MRA retains the Freedom of Choice Verification Form in the applicant's record.

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix B-8: Access to Services by Limited English Proficient 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):

DADS’ operational policy A-572 acknowledges the department’s legal obligation to ensure that programs and services are accessible to the diverse population of Texas and requires DADS service delivery to comply with state and federal laws and mandates.

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

The Language Services Unit of the Communications Office coordinates translations for DADS. DADS routinely provides Spanish translation of forms and letters and is responsive to other translation needs.

MRA service coordinators and TxHmL Program providers must assure that interpreter services are available to individuals during service planning and service delivery.

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

- a. **Waiver Services Summary.** Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *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:*

Statutory Services (check each that applies)		
Service	Included	Alternate Service Title (if any)
Case Management	<input type="checkbox"/>	
Homemaker	<input type="checkbox"/>	
Home Health Aide	<input type="checkbox"/>	
Personal Care	<input type="checkbox"/>	
Adult Day Health	<input type="checkbox"/>	
Habilitation	<input type="checkbox"/>	
Residential Habilitation	<input type="checkbox"/>	
Day Habilitation	<input checked="" type="checkbox"/>	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	<input type="checkbox"/>	
Supported Employment	<input checked="" type="checkbox"/>	
Education	<input type="checkbox"/>	
Respite	<input checked="" type="checkbox"/>	
Day Treatment	<input type="checkbox"/>	
Partial Hospitalization	<input type="checkbox"/>	
Psychosocial Rehabilitation	<input type="checkbox"/>	
Clinic Services	<input type="checkbox"/>	
Live-in Caregiver (42 CFR §441.303(f)(8))	<input type="checkbox"/>	
Other Services (select one)		
<input type="radio"/>	Not applicable	
<input checked="" type="radio"/>	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute (<i>list each service by title</i>):	
a.	Minor Home Modifications	
b.	Skilled Nursing	

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C: Participant Services
 HCBS Waiver Application Version 3.3 – October 2005

c.	Adaptive Aids	
d.	Community Support	
e.	Behavioral Support	
f.	Specialized Therapies (Speech and Language Pathology; Audiology; Occupational Therapy; Physical Therapy and Dietary)	
g.	Dental Treatment	
h.	Employment Assistance	
Extended State Plan Services (select one)		
<input type="radio"/>	Not applicable	
<input checked="" type="checkbox"/>	The following extended State plan services are provided (<i>list each extended State plan service by service title</i>):	
a.	Prescription Medications	
Supports for Participant Direction (select one)		
<input checked="" type="checkbox"/>	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.	
<input type="radio"/>	Not applicable	
Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	X	Support Consultation Services
Financial Management Services	X	
Other Supports for Participant Direction (<i>list each support by service title</i>):		
a.		
b.		
c.		

State:	TEXAS #0403
Effective Date	March 1, 2007

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants (*check each that applies*):

<input checked="" type="checkbox"/>	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). <i>Complete item C-1-c.</i>
<input type="checkbox"/>	As an administrative activity. <i>Complete item C-1-c.</i>
<input type="checkbox"/>	Not applicable – Case management is not furnished as a distinct activity to waiver participants. <i>Do not complete Item C-1-c.</i>

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

DADS contracts with local community centers, established in accordance with Texas Health and Safety Code, Chapter 534, and with a local Council of Government (COG), established in accordance with Texas Local Government Code, Chapter 391. These entities have been designated by DADS as mental retardation authorities in accordance with Texas Health and Safety Code, §533.035, and, as part of their contractual responsibilities, provide Targeted Case Management for TxHmL waiver program participants.

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C-2: General Service Specifications

- 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*):

<input checked="" type="radio"/>	<p>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):</p> <p>Program providers, MRAs, and participant employers must comply with the Texas Health and Safety Code (THSC), Chapter 250 by taking the following actions regarding applicants, employees, and contractors:</p> <p>(A) Obtain criminal history record information from the Texas Department of Public Safety that relates to an unlicensed applicant, employee, or contractor whose duties would or do involve direct contact with a consumer, and</p> <p>(B) Refrain from employing or contracting with, or immediately discharge, a person who has been convicted of an offense that bars employment under THSC, §250.006, or an offense that the program provider or participant employer determines is a contraindication to the person's employment or contract to provide services to the individual.</p> <p>Providers are required to maintain documentation of the criminal history checks performed.</p> <p>During on-site reviews of program providers, Consumer Directed Service Agencies (CDSAs) and MRAs, DADS monitors for completion of criminal history checks as required.</p>
<input type="radio"/>	<p>No. Criminal history and/or background investigations are not required.</p>

- 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*):

State:	TEXAS #0403
Effective Date	March 1, 2007

<input checked="" type="radio"/>	<p>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):</p>
	<p>Program providers and participant employers must comply with the Texas Health and Safety Code (THSC), Chapters 250 and 253, by taking the following action regarding applicants, employees, and contractors:</p> <p>(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 a consumer of a facility or has misappropriated a consumer's property, and</p> <p>(B) Search the Employee Misconduct Registry maintained by DADS in accordance with THSC, Chapter 253, and refrain from employing or contracting with or immediately discharge, a person whose duties would or do involve direct contact with a consumer, and who is designated in the registry as having abused, neglected, or exploited a consumer or has misappropriated a consumer's property.</p> <p>Program providers, CDSAs and MRAs are required to maintain documentation of the Nurse Aide Registry and Employee Misconduct Registry checks performed. During on-site reviews of DADS monitors for completion of required registry checks.</p>
<input type="radio"/>	<p>No. The State does not conduct abuse registry screening.</p>

c. Services in Facilities Subject to §1616(e) of the Social Security Act. Select one:

<input checked="" type="radio"/>	<p>No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. <i>Do not complete Items C-2-c.i – c.iii.</i></p>
<input type="radio"/>	<p>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>Complete Items C-2-c.i –c.iii.</i></p>

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit

State:	TEXAS #0403
Effective Date	March 1, 2007

- 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.

- iii. Scope of Facility Standards.** By type of facility listed in Item C-2-c-i, specify whether the State’s standards address the following (*check each that applies*):

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

State:	TEXAS #0403
Effective Date	March 1, 2007

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:*

<input checked="" type="radio"/>	No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
<input type="radio"/>	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 <i>extraordinary care</i> 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. <i>Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.</i>

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:*

<input type="radio"/>	The State does not make payment to relatives/legal guardians for furnishing waiver services.
<input type="radio"/>	The State makes payment to relatives/legal guardians under <i>specific circumstances</i> 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. <i>Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.</i>
<input type="radio"/>	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-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.</i>

State:	TEXAS #0403
Effective Date	March 1, 2007

X	<p>Other policy. <i>Specify:</i></p> <p>Relatives and guardians, who are not legally responsible for the individual, and who meet qualifications, may provide TxHmL service components with the following exceptions</p> <p>Community Support and respite may not be provided by persons, including guardians and relatives, who live with the individual. Guardians and persons related to the individual within the fourth degree of consanguinity or within the second degree of affinity may not provide Behavioral Support services or Adaptive Aids for the individual.</p> <p>Documentation requirements are the same for relatives and guardians who are service providers as for all other service providers. Program providers must assure completion of required documentation and CDSAs require submission of required documentation before paying the provider of services and submitting a billing claim.</p> <p>During billing and payment reviews of TxHmL Program providers and reviews of CDSAs, DADS staff monitors to determine compliance with policies concerning eligibility of individual providers and completion of required documentation.</p>
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- 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:

	<p>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 CFR §431.51:</p> <p>In order to obtain a provider agreement as a TxHmL Program provider, a provider applicant must apply for such in accordance with 40 TAC Part 1, Chapter 9, Subchapter Q, relating to Enrollment of Medicaid Waiver Program Providers. Enrollment of providers is conducted two times per year under these rules.</p> <p>Providers currently contracted as providers in the Home and Community-based Services Program (HCS) (waiver # 0110) may also be enrolled as TxHmL program providers under the following conditions.</p> <p>---Upon request of a provisionally certified HCS provider, DADS may provisionally certify the HCS provider as a TxHmL provider. DADS provisionally certifies only those HCS applicants that:</p> <p>(A) Demonstrate 100 percent compliance with the program provider principles on the self-assessment by the end of the orientation for waiver program providers and complete the entire orientation for waiver program providers; and</p> <p>(B) Comply with all requirements of 40 TAC, Part 1, Subchapter Q, §9.704.</p> <p>Upon request of an HCS provider that is certified, DADS may <i>certify</i> the provider as a TxHmL provider. An HCS provider becomes certified after passing a certification review conducted by DADS no later than 120 days following the enrollment of the provider's first consumer.</p> <p>Qualified TxHmL Program providers agree to provide all TxHmL program services. This model of service delivery has been approved by CMS since 1985 and is in use in other currently CMS-approved Texas home and community-based services waivers. This model of service delivery accomplishes the following for TxHmL Program consumers:</p> <ul style="list-style-type: none"> ▪ ensures the availability of each service component across the state, even in rural areas where-without the use of our current definition of qualified provider--not all service components of the waiver would be readily accessible; ▪ recognizes that a vast majority of consumers are not single service users but require supports across service disciplines that must be closely integrated and coordinated to achieve beneficial outcomes;
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State:	TEXAS #0403
Effective Date	March 1, 2007

- **promotes effective response to temporary or permanent changes in consumers' service needs as provider agencies are required to make all services components available when and as they are needed by consumers;**
- **establishes a single point of accountability for provision of needed services; and**
- **decreases administrative costs.**

In addition to promoting efficient service delivery, the TxHmL Program service delivery model does not compromise a consumer's choice of qualified provider agencies or providers of individual service components. In all 254 counties-- no matter how sparsely populated-- consumers have a choice between at least two provider agencies. In most cases, consumers have a choice among numerous provider agencies. With regard to a consumer's choice of an individual to provide a particular service component, state rules governing the operation of the TxHmL Program set forth in §9.579(c), 40 Texas Administrative Code, Part 1, Chapter 9., Subchapter N, require the TxHmL Program provider agency to... employ or contract with a service provider of the individual's or LAR's choice if that service provider:

- (1) is qualified to provide the service component;**
- (2) will provide the service within the direct services portion of the applicable TxHmL Program rate and;**
- (3) will contract with or be employed by the program provider.**

Information for obtaining a TxHmL contract is provided by contacting the DADS Community Services Contracts unit.

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification			
Service Title:	Day Habilitation		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input checked="" type="checkbox"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="checkbox"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="checkbox"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>The Day Habilitation service component provides participants assistance with acquiring, retaining, or improving self-help, socialization, and adaptive skills necessary to live successfully in the community and participate in home and community life. Day habilitation provides participants with individualized activities in environments designed to foster the development of skills and behavior supportive of greater independence and personal choice, and consistent with achieving the outcomes identified in the participant's person-directed plan. Activities are also designed to reinforce therapeutic outcomes targeted by other waiver service components, school, or other support providers. Day Habilitation is normally furnished in a group setting other than the individual's residence for up to 6 hours a day, five days per week on a regularly scheduled basis.</p> <p>Day Habilitation includes personal assistance for participants who cannot manage their personal care needs during the day habilitation activity, and assistance with medications and the performance of tasks delegated by a registered nurse in accordance with state law. This component also provides transportation during day habilitation activities necessary for the individual's participation in those activities.</p> <p>Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).</p> <p>Day Habilitation may not be provided to a participant at the same time Supported Employment, hourly-reimbursed Respite, or Community Support is provided.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
N/A			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>
	Participant Employer		Agency. List the types of agencies: Agencies holding a TxHmL Provider Agreement
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>
			Relative/Legal Guardian

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C: Participant Services
 HCBS Waiver Application Version 3.3 – October 2005

Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Individual or Agency			<p>Employee Requirements: The provider of the day habilitation service component must be 18 years of age. The provider must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the participant to be served as demonstrated through a written competency-based assessment; and at least three personal references from persons not related by blood that evidence the ability to provide a safe and healthy environment for the individual(s) to be served.</p> <p>Transportation of individuals must be provided in accordance with applicable state laws. Assisting with tasks delegated by a Registered Nurse must be in accordance with state law.</p> <p>The provider of day habilitation must complete initial and periodic training provided by the participant or by the program provider in accordance with 40 TAC §9.579(d), (relating to Certification Principles: Qualified Personnel),</p>

Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Individual	Participant Employer and Consumer Directed Service Agency		Prior to hiring	
	DADS staff		Biennial on-site reviews	
Agency	Provider Agency		Prior to hiring	
	DADS staff		Annual on-site reviews	
Service Delivery Method				
Service Delivery Method (check each that applies):	X	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C: Participant Services
 HCBS Waiver Application Version 3.3 – October 2005

Service Title:	Employment Assistance		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>The Employment Assistance service component helps an individual to locate or develop paid employment in the community by assisting the individual to identify his or her employment preferences, his or her job skills, his or her requirements for the work setting and work conditions, and prospective employers offering employment compatible with the individual's identified preferences, skills, and requirements. This service component facilitates the individual's employment by contacting prospective employers on behalf of the individual and negotiating the individual's employment.</p> <p>Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
N/A			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>
	Participant Employer		Agency. List the types of agencies: Agencies holding a TxHmL Provider Agreement
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>
			Relative/Legal Guardian

Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individual or Agency			<p>Employee Requirements: The provider of the employment assistance service component must be 18 years of age. The provider must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served as demonstrated through a written competency-based assessment; and at least three personal references from persons not related by blood that evidence the ability to provide a safe and healthy environment for the individual(s) to be served.</p> <p>Transportation of individuals must be</p>

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C: Participant Services
 HCBS Waiver Application Version 3.3 – October 2005

			<p>provided in accordance with applicable state laws. Assisting with tasks delegated by a Registered Nurse must be in accordance with state law.</p> <p>The provider of employment assistance services must complete initial and periodic training provided by the participant or, by the program, provider in accordance with 40 TAC §9.579(d), (relating to Certification Principles: Qualified Personnel).</p>
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State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C: Participant Services
 HCBS Waiver Application Version 3.3 – October 2005

Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Individual	Participant Employer and Consumer Directed Service Agency DADS staff		Prior to hiring Biennial on-site reviews	
Agency	Provider Agency DADS staff		Prior to hiring Annual on-site reviews	
Service Delivery Method				
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

State:	TEXAS #0403
Effective Date	March 1, 2007

Service Specification			
Service Title:	Supported Employment		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input checked="" type="checkbox"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="checkbox"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="checkbox"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>Supported employment provides on-going individualized support services in an integrated setting that enables individuals for whom competitive employment at or above the minimum wage is unlikely without the provision of supports and who, because of their disabilities, need supports, to perform in a regular work setting. Employment is work for which an individual is compensated by his or her employer in accordance with the Fair Labor Standards Act. Supported employment is provided in an integrated work setting (i.e., a job site where generally no more than one employee or 3 percent of the employees have disabilities) unless the individual's person-directed plan indicates otherwise or the employer subsequently hires an additional employee with disabilities who is receiving services from a provider other than the individual's program provider or is not receiving services. The supported employment component includes services and supports, including supervision and training, essential to sustain paid work by an individual.</p> <p>Supported Employment is provided away from the individual's place of residence. It does not include payment for the supervisory activities rendered as a normal part of the business setting.</p> <p>Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).</p> <p>FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:</p> <p>(A) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;</p> <p>(B) Payments that are passed through to users of supported employment programs; or</p> <p>(C) Payments for training that is not directly related to an individual's supported employment program.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
N/A			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>
		Participant Employer	Agency. List the types of agencies: Agencies holding a TxHmL Provider Agreement
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>
			Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individual or Agency			Employee Requirements: The provider of the supported employment service component must be 18 years of age. The employee provider must have a high school diploma or Certificate of High School Equivalency (GED credentials) or

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C: Participant Services
 HCBS Waiver Application Version 3.3 – October 2005

			<p>documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served as demonstrated through a written competency-based assessment; and at least three personal references from persons not related by blood that evidence the ability to provide a safe and healthy environment for the individual(s) to be served.</p> <p>Transportation of individuals must be provided in accordance with applicable state laws. Assisting with tasks delegated by a Registered Nurse must be in accordance with state law.</p> <p>The provider of supported employment must complete initial and periodic training provided by the recipient or, by the program provider in accordance with 40 TAC §9.579(d), (relating to Certification Principles: Qualified Personnel).</p>
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Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual	Participant Employer and Consumer Directed Service Agency DADS staff	Prior to hiring Biennial on-site reviews
Agency	Provider Agency DADS staff	Prior to hiring Annual on-site reviews

Service Delivery Method

Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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Service Specification

Service Title: Respite

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

- | | |
|-------------------------------------|--|
| <input checked="" type="checkbox"/> | Service is included in approved waiver. There is no change in service specifications. |
| <input type="checkbox"/> | Service is included in approved waiver. The service specifications have been modified. |
| <input type="checkbox"/> | Service is not included in the approved waiver. |

Service Definition (Scope):

The respite service component is provided for the planned or emergency short-term relief of the unpaid

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C: Participant Services
 HCBS Waiver Application Version 3.3 – October 2005

Caregiver of an individual when the caregiver is temporarily unavailable to provide supports due to non-routine circumstances. This component provides an individual with personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of behavioral support or specialized therapies activities; assistance with medications and the performance of tasks delegated by a Registered Nurse in accordance with state law; and supervision of the individual's safety and security. This component includes habilitation activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills.

All other waiver and non-waiver services indicated on the individual's service plan may be provided during the period of respite except that hourly-reimbursed respite may not be provided at the same time Community Support, Supported Employment or Day Habilitation is provided. FFP will not be claimed for the cost of room and board except when provided as part of respite furnished in a facility approved by the State that is not a private residence.

Respite will be provided in an individual's home or place of residence and in facilities that meet the state standards for survey and certification.

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

N/A

Provider Specifications

Provider Category(s) (check one or both):	X	Individual. List types:	X	Agency. List the types of agencies:
		Participant Employer		Agencies holding a TxHmL Provider Agreement
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	X	Relative/Legal Guardian

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C: Participant Services
 HCBS Waiver Application Version 3.3 – October 2005

Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Individual or Agency			<p>Employee Requirements: The provider of the respite service component must be 18 years of age. The employee provider must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served as demonstrated through a written competency-based assessment; and at least three personal references from persons not related by blood that evidence the ability to provide a safe and healthy environment for the individual(s) to be served.</p> <p>Transportation of individuals must be provided in accordance with applicable state laws. Assisting with tasks delegated by a Registered Nurse must be in accordance with state law.</p> <p>The provider must not live with the individual.</p> <p>The provider of respite must complete initial and periodic training provided by the recipient or, by the program provider in accordance with 40 TAC §9.579(d), (relating to Certification Principles: Qualified Personnel.</p>

Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Individual	Participant Employer and Consumer Directed Service Agency DADS staff		Prior to hiring Biennial on-site reviews	
Agency	Provider Agency DADS staff		Prior to hiring Annual on-site reviews	
Service Delivery Method				
Service Delivery Method (check each that applies):	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
Service Specification				
Service Title:	Community Support			

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C: Participant Services
 HCBS Waiver Application Version 3.3 – October 2005

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

<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.

Service Definition (Scope):

The Community Support service component provides services and supports in an individual's home and at other community locations such as city bus terminals, libraries, or stores, etc. that are necessary to achieve outcomes identified in the individual's person-directed plan. This component provides habilitative or support activities that provide, foster improvement of, or facilitate an individual's ability to perform functional living skills and other activities of daily living. Habilitative or support activities are provided that foster improvement of or facilitate an individual's ability and opportunity to participate in typical community activities, including activities that lead to successful employment; to access and use available non-waiver program services or supports for which the individual may be eligible; and to establish or maintain relationships with people who are not paid service providers that expand or sustain the individual's natural support network. The community support component provides assistance with medications and the performance of tasks delegated by a Registered Nurse in accordance with state law. Transportation or assistance in obtaining transportation is provided by this component the cost of which is included in the rate paid to the program provider.

This component does not include payment for room or board and may not be provided at the same time that the hourly-reimbursed Respite, Day Habilitation, or Supported Employment service component is provided.

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

N/A

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Participant Employer		Agencies holding a TxHmL Provider Agreement

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

	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian
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Provider Qualifications *(provide the following information for each type of provider):*

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individual or Agency			Employee Requirements: The provider of the community support service component must be 18 years of age. The employee provider must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served as demonstrated through a written competency-based assessment; and at least three personal references from persons not related by blood that evidence the ability to provide a safe and healthy environment for the individual(s) to be

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C: Participant Services
 HCBS Waiver Application Version 3.3 – October 2005

			<p>served.</p> <p>Transportation of individuals must be provided in accordance with applicable state laws. Assisting with tasks delegated by a Registered Nurse must be in accordance with state law.</p> <p>The provider must not live with the individual.</p> <p>The provider of community support must complete initial and periodic training provided by the recipient or by the program provider in accordance with 40 TAC §9.579(d), (relating to Certification Principles: Qualified Personnel).</p>
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Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual	Participant Employer and Consumer Directed Service Agency DADS staff	Prior to hiring Biennial on-site reviews
Agency	Provider Agency DADS staff	Prior to hiring Annual on-site reviews

Service Delivery Method				
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

Service Specification	
Service Title:	Minor Home Modifications
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>This service component provides physical adaptations to an individual’s home required to address specific needs identified by an individual’s service plan. Minor home modifications are necessary to ensure the health, welfare, and safety of the individual, or to enable the individual to function with greater independence in his or her home. Without the modification, the individual would require institutionalization. Modifications may include the installation of ramps and grab-bars, widening of doorways, and other specialized accessibility adaptations, modification of kitchen and bathroom facilities, or safety adaptations necessary for the welfare of the individual.</p> <p>Excluded are those adaptations or improvements to the home, which are of general utility, and are not of direct medical or remedial benefit to the individual. Examples of items excluded are installation of carpeting, roof repair, installation of central air conditioning, major home renovations, and construction of additional rooms or</p>	

State:	TEXAS #0403
Effective Date	March 1, 2007

other modifications, which add to the total square footage of the home.

All minor home modifications must be authorized by the individual’s service planning team. Any modification or combination of modifications costing more than \$1,000 must be authorized by the team based on prior written evaluations and recommendations from the individual’s physician, a licensed occupational or physical therapist, or a psychologist or behavior analyst qualified to assess the individual’s need for the specific minor home modification. The written evaluation must document the necessity and appropriateness of the minor home modification to meet the specific needs of the individual.

Minor Home Modifications must be provided in accordance with applicable State or local building codes and are limited to the following including the repair and/or maintenance of modifications:

- (A) Purchase or repair of wheelchair ramps
 - Construction or repair of wheelchair ramps and/or landings to A.D. A. specifications
- (B) Modifications to bathroom facilities
 - (1) roll-in showers
 - (2) sink adaptations
 - (3) bathtub adaptations
 - (4) toilet adaptations
 - (5) water faucet controls
 - (6) floor urinal and bidet adaptations
 - (7) plumbing adaptations
 - (8) turnaround space adaptations
- (C) Modifications to kitchen facilities
 - (1) sink adaptations
 - (2) sink cut-outs
 - (3) turnaround space adaptations
 - (4) water faucet controls
 - (5) plumbing adaptations
 - (6) worktable/work surface adjustments
 - (7) cabinetry adjustments
- (D) Specialized accessibility and safety adaptations
 - (1) door widening
 - (2) floor adaptations for health/safety
 - (3) grab bars and handrails
 - (4) automatic door openers, adapted wall switches/outlets, specialized doorbells and door scopes
 - (5) voice activated, light activated, motion activated, and electronic devices
 - (6) fire alarm adaptations (to existing systems only)
 - (7) medically necessary heating/cooling adaptations prescribed by a physician utilized to manage symptoms of a seizure disorder, respiratory or cardiac conditions, or inability to regulate body temperature
 - (8) lever door handles
 - (9) barrier free lifts
 - (10) safety glass/film adaptations and safety padding adaptations

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

The maximum lifetime expenditure for this service component is \$7,500. Once that maximum is reached, \$300 per service plan year per individual will be allowed for repair, replacement, or additional modifications.

If necessary, an individual’s service coordinator assists the individual in locating additional resources through family or local community organizations, including the local MRA, and other natural supports or seeking funding through non-waiver resources local Mental Retardation Authorities, or local community agencies. To the extent that the above efforts are unsuccessful, and the State finds that the absence of sufficient service(s) prevents the State from assuring the individual’s health and welfare in the community, the following will apply:

- The individual will be given an opportunity to request services through another existing home and

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C: Participant Services
 HCBS Waiver Application Version 3.3 – October 2005

community-based service program for which the individual may be eligible;				
<ul style="list-style-type: none"> • The participant will be assisted in seeking admission to an ICF/MR, if appropriate; and • The individual will be informed of and given the opportunity to request a fair hearing in accordance with 1 TAC Chapter 357, Subchapter A, if the State proposes to terminate the participant's waiver eligibility. 				
Provider Specifications				
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Participant Employer		Agencies holding a TxHmL Provider Agreement
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian

Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individual or Agency			Qualified contractors provide minor home modifications in accordance with state and local building codes and other applicable regulations. The provider of minor home modifications must complete initial and periodic training provided by the recipient or by the program provider in accordance with 40 TAC §9.579(d), (relating to Certification Principles: Qualified Personnel).

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual	Participant Employer and Consumer Directed Service Agency DADS staff	Prior to completing service agreement Biennial on-site reviews
Agency	Provider Agency DADS staff	Prior to completing service agreement Annual on-site reviews

Service Delivery Method				
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

Service Specification	
Service Title:	Adaptive Aids
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	

State:	TEXAS #0403
Effective Date	March 1, 2007

<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.

Service Definition (Scope):

This service component provides devices, controls, or appliances that are necessary to address specific needs identified by the individual's service plan. Adaptive aids enable individuals to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live. Adaptive aids include items that assist an individual with mobility and communication and ancillary supplies and equipment necessary to the proper functioning of such items. Also included are medically necessary supplies and items needed for life support. Items reimbursed with waiver funds must be in addition to any medical equipment and supplies furnished under the Medicaid State plan. All items must meet applicable standards of manufacture, design, and installation.

An adaptive aid is provided for a specific individual and becomes the exclusive property of that individual. Excluded are those items and supplies, which are not of direct medical or remedial benefit to the individual and items and supplies that are available to the individual through the Medicaid State plan, through other governmental programs, or through private insurance. The individual's service planning team must authorize all adaptive aids. Items costing more than \$500.00 must be authorized by the service planning team based upon written evaluations and recommendations by the individual's physician, a licensed occupational or physical therapist, a psychologist or behavior analyst, a licensed nurse, a licensed dietician, or a licensed audiologist or speech/language pathologist qualified to assess the individual's need for the specific adaptive aid. The written evaluation and recommendation must document the necessity and appropriateness of the adaptive aid to meet the specific needs of the individual.

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

Lifts

- (1) Vehicle lift adaptations for a vehicle owned by an individual, an individual's family member, or foster companion care provider if it is the primary mode of transportation for the individual (available only at 5-year intervals and proof of ownership by the individual, family member, or foster/companion care provider must be submitted). *Repair and maintenance cost that exceeds the warranty does not have to meet the 5-year interval requirement.
- (2) Hydraulic, manual or other electronic lifts
- (3) Transfer benches

Mobility aids

- (1) Crutches, walkers, canes
- (2) Orthotic devices, orthopedic shoes and braces
- (3) Manual or electric wheelchairs and necessary accessories
- (4) Forearm platform attachments for walkers and motorized wheelchairs
- (5) Portable/modular wheelchair ramps
- (6) Batteries and chargers for mobility aids
- (7) Gait trainers, gait belts
- (8) Strollers, pushchairs, travel seats

Positioning Devices

- (1) Hospital beds, cribs
- (2) Standing boards/frames, positioning chairs, wedges
- (3) Trapeze bars
- (4) Lift chair to assist in standing or sitting (lift mechanism is an item reimbursable through Medicaid), replacement slings
- (5) Bath/shower chairs
- (6) Potty/commode chairs
- (7) Bathtub rails

State:	TEXAS #0403
Effective Date	March 1, 2007

Control switches/pneumatic switches and devices

- (1) Sip and puff controls
- (2) Adaptive switches

Environmental control units

- (1) Adapted locks
- (2) Electronic control units
- (3) Voice activated, light activated, and motion activated devices

Medically necessary supplies

- (1) Diapers, diaper wipes and disposable gloves
- (2) Nutritional supplements such as Ensure wafers, powder mix, liquid or multi-vitamins for individuals with medical condition requiring a nutritional supplement
- (3) Enteral feeding formulas and supplies
- (4) Medically necessary supplies for tracheotomy care, decubitus care, ostomy care, respirator/ventilator care, or catheterization
- (5) Glucose monitors, supplies for individual's use in self-monitoring
- (6) Adapted medication dispensers, pill crushers
- (7) Air humidifiers, purifiers and specialized air filters
- (8) Muscle stimulators
- (9) Temporary lease or rental of medically necessary durable medical equipment to allow for equipment repair, purchase or replacement
- (10) Urinals
- (11) Specialized fever thermometers
- (12) Specialized scales
- (13) Medical support hose
- (14) Specialized clothing/dressing aids, bibs
- (15) Specialized or treated mattresses/covers
- (16) Egg-crate, sheepskin and other medically necessary mattress pads and covers
- (17) Cleft plate feeder
- (18) Blood pressure and pulse monitor for individual's use in self-monitoring
- (19) Eyeglasses

Communication aids (including batteries)

- (1) Direct selection, alphanumeric, scanning and/or encoding communicators
- (2) Speech amplifiers, and augmentative devices
- (3) Interpreter service (not for routine daily communication)
- (4) Repair and maintenance of communication aids
- (5) Emergency response systems/service, medical alert bracelets
- (6) Communication boards or books
- (7) Closed-captioning devices for persons with hearing impairments
- (8) Signature stamps for persons with visual impairment
- (9) Signature guides for persons with visual impairment
- (10) Personal computers and accessories to augment receptive and expressive communication
- (11) Specialized training for augmentative communication programs, not to exceed \$1000 per service plan year
- (12) Hearing aids, batteries

Adaptive/modified equipment for activities of daily living

- (1) Reachers
- (2) Stabilizing devices such as Dycem mats
- (3) Holders
- (4) Adapted/modified dinnerware, eating/drinking utensils, meal preparation devices
- (5) Specialized clocks/wristwatches for persons with visual or hearing impairments
- (6) Electric razors or electric toothbrushes for persons with muscular weakness or limited range of motion

State:	TEXAS #0403
Effective Date	March 1, 2007

- (7) Speaker telephones, “large button” or Braille telephones for use by persons who are verbal but cannot use a conventional telephone
- (8) Microwave ovens if use of a conventional oven presents a safety hazard
- (9) Adaptive bathing tools (e.g. hand held shower devices)

Safety restraints and safety devices

- (1) Safety restraints, wheelchair tie downs
- (2) Bed rails
- (3) Safety padding
- (4) Helmets (due to seizure disorder or other medical condition)
- (5) Adaptations to furniture

State:	TEXAS #0403
Effective Date	March 1, 2007

Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
The maximum amount available for adaptive aids is \$6,000 per individual per service plan year.			
If necessary, an individual's service coordinator assists the individual in locating additional resources through family or local community organizations, including the local MRA, and other natural supports or seeking funding through non-waiver resources local Mental Retardation Authorities, or local community agencies. To the extent that the above efforts are unsuccessful, and the State finds that the absence of sufficient service(s) prevents the State from assuring the individual's health and welfare in the community, the following will apply:			
<ul style="list-style-type: none"> • The individual will be given an opportunity to request services through another existing home and community-based service program for which the individual may be eligible; • The individual will be assisted in seeking admission to an ICF/MR, if appropriate; and • The individual will be informed of and given the opportunity to request a fair hearing in accordance with 1 TAC Part 15, Chapter 357, Subchapter A, if the State proposes to terminate the individual's waiver eligibility. 			
Adaptive Aids are provided under this waiver when no other financial resource for such aids is available or when other available resources have been used. Participants who are under 21 years of age must access benefits through the Texas Health Steps--Comprehensive Care Program (EPSDT) before adaptive aids may be provided under this waiver.			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types: Participant Employer	<input checked="" type="checkbox"/>
			Agency. List the types of agencies: Agencies holding a TxHmL Provider Agreement
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
			Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individual or Agency			Adaptive aids must be provided by contractors/suppliers capable of providing aids meeting applicable standards of manufacture, design and installation. The provider of adaptive aids must complete initial and periodic training provided by the recipient or the program provider in accordance with 40 TAC §9.579(d), (relating to Certification Principles: Qualified Personnel),
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Individual	Participant Employer and Consumer Directed Service Agency DADS staff		Prior to completing service agreement Biennial on-site reviews
Agency	Provider Agency		Prior to completing service agreement

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C: Participant Services
 HCBS Waiver Application Version 3.3 – October 2005

	DADS staff	Annual on-site reviews
Service Delivery Method		
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Specification			
Service Title:	Skilled Nursing		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input checked="" type="checkbox"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="checkbox"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="checkbox"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
The skilled nursing service component provides treatment and monitoring of health care procedures prescribed by a physician/medical practitioner and/or required by standards of professional practice or state law to be performed by licensed nursing personnel.			
Skilled nursing is provided under this waiver when no other financial resource for such service is available or when other available resources have been used. Participants who are under 21 years of age must access skilled nursing benefits through the Texas Health Steps--Comprehensive Care Program (EPSDT) before skilled nursing may be provided under this waiver.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
N/A			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types: Participant Employer	<input checked="" type="checkbox"/>
			Agency. List the types of agencies: Agencies holding a TxHmL Provider Agreement
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>
			Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individual or Agency	Registered Nurse (Texas Occupations Code Chapter 301) Licensed Vocational Nurse (Texas Occupations Code Chapter 301)		The provider of nursing must complete initial and periodic training provided by the recipient or by the provider in accordance with 40 TAC §9.579(d), (relating to Certification Principles: Qualified Personnel).

State:	TEXAS #0403
Effective Date	March 1, 2007

Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Individual	Participant Employer and Consumer Directed Service Agency		Prior to completing service agreement; prior to expiration of license.	
	DADS staff		Biennial on-site reviews	
Agency	Provider Agency		Prior to completing service agreement; prior to expiration of license.	
	DADS staff		Annual on-site reviews	
Service Delivery Method				
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

Service Specification				
Service Title:	Behavioral Supports			
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>				
<input checked="" type="checkbox"/>	Service is included in approved waiver. There is no change in service specifications.			
<input type="checkbox"/>	Service is included in approved waiver. The service specifications have been modified.			
<input type="checkbox"/>	Service is not included in the approved waiver.			
Service Definition (Scope):				
<p>The Behavioral Support service component provides specialized interventions that assist an individual to increase adaptive behaviors to replace or modify maladaptive or socially unacceptable behaviors that prevent or interfere with the individual's inclusion in home and family life or community life. The component includes assessment and analysis of assessment findings of the behavior(s) to be targeted so that an appropriate behavioral support plan may be designed; development of an individualized behavioral support plan consistent with the outcomes identified in the individual's person-directed plan; training of and consultation with family members or other support providers and, as appropriate, with the individual in the purpose/objectives, methods and documentation of the implementation of the behavioral support plan or revisions of the plan; monitoring and evaluation of the success of the behavioral support plan implementation; and modification, as necessary, of the behavioral support plan based on documented outcomes of the plan's implementation.</p> <p>Behavioral Supports is provided under this waiver when no other financial resource for such service is available or when other available resources have been used. Participants who are under 21 years of age must first access behavioral support benefits through the Texas Health Steps--Comprehensive Care Program (EPSDT) before behavioral supports may be provided under this waiver.</p>				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
N/A				
Provider Specifications				
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
	Participant Employer		Agencies holding a TxHmL Provider Agreement	
Specify whether the service may be provided by <i>(check each that</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C: Participant Services
 HCBS Waiver Application Version 3.3 – October 2005

applies):

Provider Qualifications (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Individual or Agency	Psychologist (Texas Occupations Code Chapter 501) Psychological Associate (Texas Occupations Code Chapter 501)	DADS-certified Psychologist (40 Texas Administrative Code, Part 1 Chapter 5, Subchapter D, Section 5.153) Board-certified Behavior Analyst (Certification as Behavior Analyst by the national Behavior Analyst Certification Board, Inc.)	The provider of behavioral supports must complete initial and periodic training provided by the recipient or by the provider in accordance with 40 TAC §9.579(d), (relating to Certification Principles: Qualified Personnel).

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual	Participant Employer and Consumer Directed Service Agency DADS staff	Prior to completing service agreement; prior to expiration of license or certification Biennial on-site reviews
Agency	Provider Agency DADS staff	Prior to completing service agreement; prior to expiration of license or certification Annual on-site reviews

Service Delivery Method

Service Delivery Method (check each that applies):	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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State:	TEXAS #0403
Effective Date	March 1, 2007

Service Specification				
Service Title:	Specialized Therapies			
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>				
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.			
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.			
<input type="radio"/>	Service is not included in the approved waiver.			
Service Definition (Scope):				
<p>The specialized therapies service component provides assessment and treatment by licensed occupational therapists, physical therapists, speech and language pathologists, audiologists, and dietitians and includes training and consultation with an individual’s family members or other support providers.</p> <p>Specialized therapies include:</p> <ul style="list-style-type: none"> • Screening and assessment; • Development of therapeutic treatment plans; • Direct therapeutic intervention; • Assistance, and training with adaptive aids and augmentative communication devices • Consulting with other service providers and family members; and • Participating on the interdisciplinary team, when appropriate. <p>Specialized Therapies are provided under this waiver when no other financial resource for such therapies is available or when other available resources have been used. Participants who are under 21 years of age must first access specialized therapy benefits through the Texas Health Steps--Comprehensive Care Program (EPSDT) before specialized therapies may be provided under this waiver.</p>				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
N/A				
Provider Specifications				
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types: Participant Employer	<input checked="" type="checkbox"/>	Agency. List the types of agencies: Agencies holding a TxHmL Provider Agreement
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	
Individual or Agency	Occupational Therapist (Texas Occupations Code Chapter 454) Physical Therapist (Texas Occupations Code Chapter 453) Speech/Language Pathologist, Audiologist (Texas Occupations			

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C: Participant Services
 HCBS Waiver Application Version 3.3 – October 2005

	Code Chapter 401) Dietitian (Texas Occupations Code Chapter 701)		
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Individual	Participant Employer and Consumer Directed Service Agency DADS staff	Prior to completing service agreement; prior to expiration of license Biennial on-site reviews	
Agency	Provider Agency DADS staff	Prior to completing service agreement; prior to expiration of license Annual on-site reviews	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Specification	
Service Title:	Dental Treatment
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input checked="" type="checkbox"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="checkbox"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="checkbox"/>	Service is not included in the approved waiver.

Service Definition (Scope):
<p>Elements of this component include the following:</p> <p>(A) Emergency dental treatment. Those procedures necessary to control bleeding, relieve pain, and eliminate acute infection; operative procedures that are required to prevent the imminent loss of teeth; and treatment of injuries to the teeth or supporting structures.</p> <p>(B) Preventive dental treatment. Examinations, oral prophylaxes, and topical fluoride applications.</p> <p>(C) Therapeutic dental treatment. Treatment that includes, but is not limited to, pulp therapy for permanent and primary teeth; restoration of carious permanent and primary teeth; maintenance of space; and limited provision of removable prostheses when masticatory function is impaired, when an existing prosthesis is unserviceable, or when aesthetic considerations interfere with employment or social development.</p> <p>(D) Orthodontic dental treatment. Procedures that include treatment of retained deciduous teeth; crossbite therapy; facial accidents involving severe traumatic deviations; cleft palates with gross malocclusion that will benefit from early treatment; and severe, handicapping malocclusions affecting permanent dentition with a minimum score of 26 as measured on the Handicapping Labio-lingual Deviation Index. Cosmetic orthodontia is excluded from the Dental Treatment component.</p> <p>Dental Treatment is provided under this waiver when no other financial resource for such treatment is available or when other available resources have been exhausted. Participants who are under 21 years of age must first access dental treatment benefits through the Texas Health Steps--Comprehensive Care Program (EPSDT) before dental treatment may be provided under this waiver.</p>

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C: Participant Services
 HCBS Waiver Application Version 3.3 – October 2005

Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
The total amount allowable for the dental treatment component is limited to a maximum expenditure of \$1,000 per individual per service plan year.			
If necessary, an individual's service coordinator assists the individual in locating additional resources through family or local community organizations, including the local MRA, and other natural supports or seeking funding through non-waiver resources local Mental Retardation Authorities, or local community agencies. To the extent that the above efforts are unsuccessful, and the State finds that the absence of sufficient service(s) prevents the State from assuring the individual's health and welfare in the community, the following will apply:			
<ul style="list-style-type: none"> • The individual will be given an opportunity to request services through another existing home and community-based service program for which the individual may be eligible; • The individual will be assisted in seeking admission to an ICF/MR, if appropriate; and • The individual will be informed of and given the opportunity to request a fair hearing in accordance with 1 TAC Part 15, Chapter 357, Subchapter A, if the State proposes to terminate the individual's waiver eligibility. 			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types: Participant Employer	<input checked="" type="checkbox"/> Agency. List the types of agencies: Agencies holding a TxHmL Provider Agreement
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/> Relative/Legal Guardian

Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individual or Agency	Dentist (Texas Occupations Code Chapter 251)		Providers of dental treatment must complete initial and periodic training provided by the recipient or by the provider in accordance with 40 TAC §9.579(d), (relating to Certification Principles: Qualified Personnel).
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Individual	Participant Employer and Consumer Directed Service Agency DADS staff		Prior to completing service agreement; prior to expiration of license Biennial on-site reviews
Agency	Provider Agency DADS staff		Prior to completing service agreement Annual on-site reviews
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

State:	TEXAS #0403
Effective Date	March 1, 2007

Service Specification	
Service Title:	Extended State Plan: Prescriptions
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
Unlimited prescribed medications beyond the three per month limit available under the Texas Medicaid State Plan are provided to individuals enrolled in the waiver, unless the individual is eligible for both Medicaid and Medicare (dually eligible). An individual who is dually eligible must obtain prescribed medications through the Medicare Prescription Drug Plan, or, for certain medications excluded from Medicare, through the Texas Medicaid State Plan.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
			Pharmacies holding a Medicaid Provider Agreement—Vendor Drug with Texas Health and Human Services Commission (HHSC)
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Agency	Pharmacy Texas State Board of Pharmacy		Must hold Vendor Drug Provider Agreement with HHSC. The provider must complete training as required by HHSC.
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Agency	Texas State Board of Pharmacy		Every 2 years
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Specification	
Service Title:	Support Consultation Services
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C: Participant Services
 HCBS Waiver Application Version 3.3 – October 2005

X	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Support consultation is an optional service component that offers practical skills training and assistance to enable an individual or his/her LAR to successfully direct those services the individual or the LAR-elect for self-direction. This component includes skills training related to recruiting, screening, and hiring workers, preparing job descriptions, verifying employment eligibility and qualifications, completion of documents required to employ an individual, managing workers, and development of effective back-up plans for services considered critical to the individual's health and welfare in the absence of the regular provider or in an emergency situation. This component provides sufficient information and assistance to assure individuals and their representatives understand the responsibilities involved with self-direction. The scope and duration of support consultation will vary depending on an individual's need for support consultation.</p> <p>Support consultation may be provided by a qualified individual associated with a CDSA selected by the participant or by an independent individual hired by the participant.</p>	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
N/A	

Provider Specifications				
Provider Category(s) <i>(check one or both):</i>	X	Individual. List types: Participant Employer	X	Agency. List the types of agencies: Consumer Directed Service Agencies contracted to provide financial management services.
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	
Individual or agency		Individual provider must have certification of successful completion of required training conducted or approved by DADS	<p>The employee provider of the support consultation service component must be at least 18 years old; have a high school diploma or Certificate of High School Equivalency (GED credentials); and has documentation of attendance and completion of initial training required by and conducted or authorized by DADS; and any ongoing training if required by and conducted or authorized by DADS.</p> <p>The support advisor does not provide service coordination or any other waiver service other than financial management services to the individual. The support advisor cannot be the individual's legal guardian; the spouse of individual's legal guardian; the individual's designated representative; or the spouse of the individual's designated representative.</p> <p>The support advisor must complete initial</p>	

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C: Participant Services
 HCBS Waiver Application Version 3.3 – October 2005

			<p>and periodic training provided by the recipient.</p> <p>Support consultation may be provided by a qualified individual associated with a CDSA selected by the participant or by an independent individual hired by the participant.</p>

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual	Participant Employer and Consumer Directed Service Agency DADS staff	Prior to completing service agreement Biennial on-site reviews
Agency	Consumer Directed Service Agency DADS staff	Prior to completing service agreement Biennial on-site reviews

Service Delivery Method

Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/>	Provider managed
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Service Specification

Service Title:	Financial Management Services
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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 (FMS) 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 FMS provider, referred to as the Consumer Directed Services Agency (CDSA) also provides assistance in the development, monitoring and revision of the individual's budget for each service component delivered through the consumer Directed Service (CDS) option and must maintain a separate account for each individual's budget. **The CDSA provides assistance in determining staff wages and benefits subject to State limits, assistance in hiring by verifying employee's citizenship status and qualifications, and conducting required background checks.** The CDSA verifies and maintains documentation of employee qualifications, including citizenship status, and documentation of services delivered. **The CDSA also 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.** The FMS provider tracks disbursement of funds and provides periodic reports to the individual of all expenditures and the status of the individual's CDS budget.

The CDSA must not provide service coordination (Targeted Case Management for Persons with Mental

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C: Participant Services
 HCBS Waiver Application Version 3.3 – October 2005

Retardation) to the participant.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
N/A

Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
		Consumer Directed Service Agencies contracted to provide financial management services.	
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian

Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Agency			<p>The provider of financial management services (FMS) must contract to be a Consumer Directed Services Agency (CDSA)</p> <p>The CDSA must successfully complete mandatory orientation and training to contract with DADS to provide financial management services.</p> <p>The CDSA must complete initial and periodic training provided.</p> <p>The CDSA must not provide service coordination (Targeted Case Management for Persons with Mental Retardation) to the participant). The CDSA 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.</p>

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency	DADS staff	Biennial on-site reviews

Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/> Provider managed

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*check each that applies*).

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; and, (f) how participants are notified of the amount of the limit.

X	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. <i>Furnish the information specified above.</i>
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State:	TEXAS #0403
Effective Date	March 1, 2007

The service components included in this waiver are classified under two broad service categories—the Community Living Service Category and the Professional and Technical Supports Service Category. The Community Living Service Category includes the following service components: Community Support, Day Habilitation, Employment Assistance, Supported Employment, and Respite. An individual’s use of any service component or combination of components included in the Community Living Service Category is limited to \$8,000 per year per individual unless DADS approves an exception to the service limit.

The Professional and Technical Supports Service Category includes the following service components: Skilled Nursing, Behavioral Support, Physical Therapy, Occupational Therapy, Dietary, Speech and Language Pathology, Audiology, Minor Home Modifications, Adaptive Aids, and Dental Treatment. An individual’s use of any service component or combination of components included in the Professional and Technical Supports Service Category is limited to \$2,000 per year per individual unless DADS approves an exception to the service limit.

As demonstrated in the two annual reports on this waiver, individuals in the TxHmL Program use those services included in the Community Living Service Category, particularly Community Support and Day Habilitation at a higher rate than those services included in the Professional and Technical Supports Category.

An individual’s service coordinator is responsible for ensuring that individuals and their representatives are informed of the service category limits and the ability to request an exception to a category limit **when the individual enrolls in the program, when the individual’s legal status changes, and on request of the individual or LAR.** The service coordinator is also responsible for ensuring that annual service limits are not exceeded and all service components included on the service plan are consistent with the individual’s demonstrated needs. If the service planning team and service coordinator determine that an individual’s need for services included under one of the two service categories exceeds the annual limit of that category, the service coordinator may request DADS to make an exception to a service category annual limit. DADS may approve such a request if the increased service limit is determined necessary to protect the individual’s health and welfare or prevent the individual’s admission to institutional services. In the event an exception to a service category limit is approved, the combination of service components included in the Community Living Service Category and the Professional and Technical Supports Service Category may not exceed \$10,000 per individual per year. Participants for whom service limit exceptions are denied will be offered an opportunity for a fair hearing in accordance with Appendix F of this request.

At the time this waiver program was developed, the State reviewed service utilization data for the general revenue funded programs operated for individuals with mental retardation and data for participants enrolled the HCS Program who lived in their own or family homes. The large majority of services used were of the type included in the Community Living Service Category (e.g., respite, community support, day habilitation). While data showed some use of services of the types included in the Professional and Technical Supports Service Category, the utilization was low or none. Based on this information, the service category limits of \$8,000 for the Community Living Service Category and \$2,000 for Professional and Technical Support Service Category were established along with processes for moving funds from one category to another when individual needs justified such. The purpose of the TxHmL Program is to provide essential service and supports to individuals who live in their own homes or with their families. These individuals have an existing natural support system, which the waiver is designed to supplement rather than replace. It is not the State’s intent to revise the cost limit during the 5 years the waiver operates, however, if an unanticipated event were to occur, the State would consider adjusting the cost limit. For example, if the State Legislature grants funding for an increase in the TxHmL reimbursement rates, the State would adjust the cost limit so that participants would not experience a decrease in the amount of services they are receiving at the time of the rate increase.

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix C: Participant Services
 HCBS Waiver Application Version 3.3 – October 2005

<input type="checkbox"/>	<p>Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. <i>Furnish the information specified above.</i></p>
<input type="checkbox"/>	<p>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. <i>Furnish the information specified above.</i></p>
<input type="checkbox"/>	<p>Other Type of Limit. The State employs another type of limit. <i>Describe the limit and furnish the information specified above.</i></p>
<input type="checkbox"/>	<p>Not applicable. The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.</p>

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Person-directed Plan (PDP)
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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 (*check each that applies*):

<input type="checkbox"/>	Registered nurse, licensed to practice in the State
<input type="checkbox"/>	Licensed practical or vocational nurse, acting within the scope of practice under State law
<input type="checkbox"/>	Licensed physician (M.D. or D.O)
<input type="checkbox"/>	Case Manager (qualifications specified in Appendix C-3)
<input checked="" type="checkbox"/>	<p>Case Manager (qualifications not specified in Appendix C-3). <i>Specify qualifications:</i></p> <p>Only an MRA service coordinator may provide case management, designated as service coordination.</p> <p>A service coordinator must have:</p> <p>(A) A bachelor's or advanced degree from an accredited college or university with a major in a social, behavioral, or human service field including, but not limited to, psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human development, gerontology, educational psychology, education, and criminal justice; or</p> <p>(B) A high school diploma or a certificate recognized by a state as the equivalent of a high school diploma and:</p> <p>(C) Two years of paid experience as a case manager in a state or federally funded Parent Case Management Program or have graduated from Partners in Policy Making; and</p> <p>(D) Personal experience as an immediate family member of an individual with mental retardation.</p> <p>The MRA, at its discretion, may require additional education and experience for staff that provide service coordination.</p> <p>The service coordinator must complete all training prescribed in rules governing the TxHmL Program located at 40 TAC Part 1, Chapter 9 Subchapter N.</p>
<input type="checkbox"/>	Social Worker. <i>Specify qualifications:</i>
<input type="checkbox"/>	Other (<i>specify the individuals and their qualifications</i>):

State:	TEXAS #0403
Effective Date	March 1, 2007

b. Service Plan Development Safeguards. *Select one:*

<input type="radio"/>	Entities and/or individuals that have responsibility for service plan development <i>may not provide</i> other direct waiver services to the participant.
<input checked="" type="radio"/>	<p>Entities and/or individuals that have responsibility for service plan development <i>may provide</i> 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. <i>Specify:</i></p> <p>As noted in Appendix C-1 (c), local community centers and a Council of Government (COG) are designated as Mental Retardation Authorities (MRA). A community center, in its role as a local MRA, provides service coordination to TxHmL Program participants in accordance with the provisions relating to Targeted Case Management (TCM) for Persons with Mental Retardation contained in the approved Texas State Medicaid Plan. Under those provisions, employees of MRAs are authorized to provide TCM. Recipients may request a change in service coordinators from the MRA but the service coordinator must be an employee of the MRA serving the geographic area where the recipient receives TxHmL Program services.</p> <p>The community center may also hold a TxHmL program provider agreement (contract) with DADS. Under the provisions of the performance agreement between DADS and the local community center, a person who provides service coordination to a participant is prohibited from providing any other direct waiver service to that individual. At the time of a participant’s enrollment, the participant’s service coordinator informs the participant and the participant’s LAR that the service coordinator may not provide other waiver services to the participant.</p>

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.

<p>The service coordinator assures that the applicant/individual and LAR participate in developing a personalized person-directed plan (PDP) that meets the individual’s identified needs and service outcomes by supporting the individual and LAR to set goals that address the needs identified during assessment and educating the individual or LAR about service delivery options and the services available through TxHmL Program that will contribute to goal achievement. The PDP must be developed in accordance with “<i>Person Directed Planning and Family Directed Planning Guidelines for Individuals Living in the Community.</i>” The service coordinator must inform the applicant/individual or LAR orally and in writing of the eligibility criteria for participation in the TxHmL Program; the services and supports provided by the TxHmL Program and the limits on those services and supports; and the reasons an individual may be discharged from the TxHmL Program.</p> <p>The MRA must assure that the individual, and family or legal representative as appropriate, can contact the service coordinator to secure information at any time regarding services and supports and service delivery options; and can request to change the PDP and services due to changes in needs, goals or preferences. At least annually, the service coordinator must present information to the individual or LAR regarding available waiver services and supports, and the available service delivery options.</p> <p>The service planning team consists of the applicant or individual, LAR, service coordinator, and other persons such as family members, service providers, or friends chosen or designated by the applicant, individual or LAR to participate in service planning.</p>
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State:	TEXAS #0403
Effective Date	March 1, 2007

- d. Service Plan Development Process** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant’s needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The MRA must assure that a service coordinator initiates, coordinates and facilitates the person-directed planning process to assure that an individual’s service plan addresses the desires and needs as identified by an individual and LAR. The service coordinator, the individual or LAR, and others (e.g., family, friends, or service providers) as chosen or designated by the individual or LAR comprise the service planning team. The service planning team must develop an initial individual service plan based on the PDP for each applicant within 45 working days of the date an applicant or LAR chooses the TxHmL Program. At least annually, the service planning team and TxHmL provider must review the individual’s PDP and initiate changes in the service plan in response to changes in the individual’s needs and identified outcomes as documented in the PDP. The individual and LAR must sign the plan to indicate understanding of, and agreement with, the plan.

Deliberations and conclusions of the service planning team must document that the TxHmL Program service components identified for inclusion in the service plan are necessary for the individual to live in the community and to prevent his or her admission to institutional services; and are sufficient, when combined with services or supports available from non-TxHmL Program sources (if applicable), to assure the individual's health and welfare in the community.

At a minimum, the PDP process and resulting plan must address the following:

- (A) A description of the needs and preferences identified by the individual and LAR;
- (B) A description of the services and supports the applicant requires to continue living in his or her own home or family home;
- (C) A description of the applicant's current existing natural supports and non-TxHmL Program services that will be or are available;
- (D) A description of individual outcomes to be achieved through TxHmL Program service components and justification for each service component to be included in the individual service plan;
- (E) Documentation that the type, frequency, and amount of each service component included in the applicant's service plan do not replace existing natural supports or non-TxHmL Program sources for the service components for which the applicant may be eligible; and
- (F) A description of actions and methods to be used to reach identified service outcomes, projected completion dates, and person(s) responsible for completion.

The service coordinator assures that the PDP process identifies and focuses on the desires and needs as identified by the individual and LAR, and the individual’s and LAR’s assessment of the services and supports being received in relation to the individual’s needs, preferences and personal goals. The service coordinator supports the individual’s and LAR’s participation in the process by encouraging the expression of preferences, goals and ambitions and providing education about the services available through the TxHmL Program as well as through other non-waiver resources for which the individual may be qualified. In addition, formal assessments regarding health, level of

State:	TEXAS #0403
Effective Date	March 1, 2007

functioning, specialized therapeutic interventions are completed as the need is identified by the service planning team. The PDP identifies and addresses risk factors, and specifies the type and frequency of waiver services and non-waiver services to be included in the individual service plan to address risk factors as well as the individual’s other needs, preferences and desired outcomes. The DADS website provides service coordinators and other service planning team members access to a “Person-directed Plan Discovery Tool,” which provides team members a number of probes that may be used to help identify areas of need, goals, abilities and strengths, and preferences.

At enrollment, as requested by the individual or LAR, and at least annually, the service coordinator must present information to the individual or LAR regarding available services and supports and the available service delivery options. The service coordinator must also inform the individual or LAR that the service coordinator will assist the individual or LAR to transfer the individual's TxHmL Program services from one program provider to another program provider or FMS provider to another program provider or FMS provider as chosen by the individual or LAR. The MRA must assure an individual or LAR is informed of the name of the individual's service coordinator and how to contact the service coordinator.

The applicant/individual and LAR, service coordinator, and other team members work together to develop a PDP and service plan that integrates TxHmL services and supports and non-waiver services (e.g., State Plan services) so that the plan’s goals may be achieved and services are complementary and not duplicative.

The PDP process and plan must include a description of actions and methods to be used to reach identified service outcomes, projected completion dates, and entity or person(s) responsible for implementing the methodology. The service plan must specify the type and amount of each service component to be provided to the individual, as well as services and supports to be provided by other, non- TxHmL Program sources during the service plan year.

The individual’s service coordinator is responsible for monitoring the implementation of the plan. The TxHmL Program provider is responsible ensuring implementation of those TxHmL service components it is assigned to provide while the individual electing the Consumer Directed Service option is responsible for ensuring implementation of self-directed services.

- 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 service coordinator ensures consideration of information from the individual and LAR, other service planning team members, and from assessments to determine any risks that might exist to health and welfare as a result of living in the community. Strategies including program service and supports and non-waiver services and supports, formal and informal, are developed to mitigate these risks, and are incorporated into the plan.

In the CDS option, the service planning team identifies services critical to the health and welfare of the individual for which a back up plan must be developed, documented in the service plan, and approved by the team. Back up plans may use paid or unpaid service providers, other third party resources and other community resources. State rules governing the TxHmL Program (40 TAC Part 1, Chapter 9, Subchapter N) require the TxHmL Program provider to ensure the continuous availability of trained and qualified employees and contractors to provide the service components in an individual service plan. Thus, program providers must implement plans that adequately prevent service interruptions or delays that may place the individual’s health or safety at risk.

State:	TEXAS #0403
Effective Date	March 1, 2007

The DADS website provides service coordinators and other service planning team members access to a “Person-directed Plan Discovery Tool,” which assists team members in considering a variety of risks such as risks related to health factors; abuse, neglect, or exploitation; and safety risks.

- 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.

Rules governing the TxHmL Program (40 TAC Part 1, Chapter 9, Subchapter N) require an MRA to:

- (A) provide a list to the individual or LAR with contact information for all TxHmL Program providers in the MRA's local service area;
- (B) assist in educating and securing tools for use by the individual or LAR in evaluating providers' experience and compatibility with the specific needs and preferences of the individual;
- (C) arrange for meetings/visits with potential TxHmL Program providers as desired by the applicant or the LAR; and
- (D) assure that the applicant's or LAR's choice of a TxHmL Program provider is documented, signed by the individual or the LAR, and retained by the MRA in the applicant's record.

These rules also require MRAs to have a mechanism to assure objectivity in the process it uses to assist an individual or LAR in the selection of a program provider and a system for training all MRA staff who may assist an individual or LAR in such process.

DADS has also posted on its website an “interview tool” individuals and the families may tailor for their own use during the process of provider selection.

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

HHSC has delegated the day-to-day approval of service plans to DADS, the delegated operating agency.

HHSC approves all criteria, processes and documentation requirements related to the development and approval of individual service plans as delegated to DADS. In addition to approving the above systems and processes, HHSC staff participate in at least one on-site TxHmL Program provider review per year. During these reviews, staff from the Medicaid agency review the operating agency's compliance with the approved service plan review requirements and verify compliance through a look-behind review process for service plans previously approved by the operating agency and those reviewed on-site during the review.

- 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:*

<input type="radio"/>	Every three months or more frequently when necessary
<input type="radio"/>	Every six months or more frequently when necessary
<input checked="" type="radio"/>	Every twelve months or more frequently when necessary
<input type="radio"/>	Other schedule (<i>specify</i>):

State:	TEXAS #0403
Effective Date	March 1, 2007

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 §74.53. Service plans are maintained by the following (*check each that applies*):

<input type="checkbox"/>	Medicaid agency
<input checked="" type="checkbox"/>	Operating agency
<input checked="" type="checkbox"/>	Case manager / MRA service coordinator
<input checked="" type="checkbox"/>	Other (<i>specify</i>):
	TxHmL Program Provider

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix 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. Also how reported to the State.

Service coordinators employed by local MRAs monitor implementation of individual service plans, individual health and welfare, and assess how well services are meeting an individual's needs and enabling the individual to achieve the goals/outcomes described in the PDP. In conducting their monitoring responsibilities, service coordinators must complete contacts in person; the frequency of which is determined by the service planning team and documented in the PDP, but must occur no less frequently than every 90 calendar days. Contacts in addition to the identified minimum may be completed in person or by telephone. The service coordinator 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 and LAR are satisfied with implementation of services; whether or not the individual's health and welfare are reasonably assured; whether or not the individual or LAR exercises free choice of providers and accesses non-waiver services including health services; and

for the participant electing the CDS option, whether or not implementation of the back-up plan has been required and, if so, document a determination made with the participant whether or not it was effective. If warranted, the service coordinator assures the backup plan is revised.

The service coordinator takes appropriate actions to address identified problems including counseling with the individual or LAR; convening a service planning meeting to resolve problems; advocating on the individual's behalf with the TxHmL Program provider or non-waiver resources. When monitoring identifies changes in needs or preferences, the service coordinator may convene service planning team meetings to address problems/identified changes or confer with service providers concerning improving implementation strategies. **If a self-directing participant's back-up plan was not effective, the service coordinator and participant determine the revisions that should be made to the plan. The service coordinator must document in the participant's record that the plan was effective or that revisions were required. The service coordinator assures that a revised back-up plan is developed whenever necessary.**

Deficiencies in service plan monitoring or implementation noted during DADS's annual or intermittent on-site reviews of MRAs or program providers are entered into the DADS Client Assignment and Registration (CARE) System. Deficiencies in this area are reported annually to HHSC through the CMS 372(S) report.

- b. Monitoring Safeguards. Select one:**

<input type="radio"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may not provide</i> other direct waiver services to the participant.
<input checked="" type="radio"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may provide</i> 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. <i>Specify:</i>

State:	TxHmL #0403
Effective Date	March 1, 2007

As noted in Appendix C-1 (c), local community centers and Councils of Government (COG) are designated as Mental Retardation Authorities (MRA). A community center, in its role as a local MRA, provides service coordination to TxHmL Program participants. The community center may also hold a TxHmL Program provider agreement (contract) with DADS. Under the provisions of the performance agreement between DADS and the local community center, a person who provides service coordination to a TxHmL Program participant is prohibited from providing any other direct waiver service to that participant.

The local MRA is held responsible for ensuring that service plan monitoring occurs as stated in the individual's PDP; required documentation is completed; and appropriate follow-up actions on monitoring findings are taken.

Local MRAs enter into a Performance Contract with DADS, which prohibits staff providing TxHmL service coordination from providing any other direct “provider” service to the participant through the TxHmL Program or other funding source such as state general revenue services, the HCS Program (waiver # 0110), or the ICF/MR Program. Rules governing the TxHmL Program prohibit the service coordinator from providing TxHmL services to an individual for whom he or she provides service coordination. In addition, staff providing service coordination to TxHmL participants is prohibited by the Performance Contract from serving as an HCS case manager, a service component of the HCS Program.

DADS provides oversight of the MRA’s role through an annual on-site review during which the MRA’s compliance with provisions of the state rules governing the TxHmL Program and the Performance Contract is evaluated.

State:	TxHmL #0403
Effective Date	March 1, 2007

Appendix E: Participant Direction of Services

[NOTE: Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.]

Applicability (select one):

<input checked="" type="radio"/>	Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
<input type="radio"/>	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):

<input type="radio"/>	Yes. The State requests that this waiver be considered for Independence Plus designation.
<input checked="" type="radio"/>	No. Independence Plus designation is not requested.

Appendix E-1: Overview

- 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.

The State intends to implement a Consumer Directed Service (CDS) option by January 1, 2008.

Participation in the CDS option provides the individual, or the LAR, the opportunity to be the employer of persons providing waiver services chosen for self-direction. Each individual or LAR electing the CDS option must receive support from a Financial Management Service (FMS) provider referred to as a Consumer Directed Service Agency (CDSA), chosen by the individual or LAR. The individual or the LAR is the employer and may appoint a designated representative (DR) to assist with employer responsibilities. The individual or LAR may choose to receive Support Consultation provided by a Support Advisor.

An individual or the individual’s LAR may choose to direct any service component provided through the waiver as listed in Appendix C except Extended State Plan Services: Prescriptions.

An alternate service delivery option, the current traditional agency model (provider-managed service delivery) is available to provide authorized services that the individual/LAR elects not to self-direct. Under the alternate method, individuals choose a certified and contracted TxHmL Program provider capable of delivering the full array of TxHmL Program service components.

When choosing to self-direct authorized waiver services, the individual receiving those services or his LAR is the common-law employer of service providers and has decision-making authority over providers of those services. Services delivered through providers not required by state or federal regulations to be employed are retained under an agreement with the employer for the delivery of authorized service components (e.g., support consultation, licensed therapy services, nursing). The employer or DR, with the assistance and final approval of the CDSA, budgets authorized funds for

State:	TEXAS #0403
Effective Date	March 1, 2007

those services to be delivered through the CDS option.

Support Consultation is an optional service available to provide assistance and skills training for the individual, LAR, or DR in meeting employer responsibilities and succeeding in the CDS option. When authorized by the individual’s service planning team, the individual may receive this service from a Support Advisor associated with a CDSA or from a qualified independent Support Advisor.

After the TxHmL CDS option is implemented in the program, an individual’s service coordinator will inform the individual and LAR of the option to self-direct available waiver services at the time of enrollment in the waiver and at least annually thereafter. Individuals enrolled in TxHmL after the CDS option is implemented will be offered the option when the individual’s service plan is renewed for another year and at least annually thereafter, or upon request of the individual or LAR. The individual or LAR may elect at any time to choose the CDS option, terminate participation in the CDS option, or to change CDSAs.

The CDS option is available statewide to all TxHmL Program participants or their LARs.

Entities/individuals involved in supporting participants or participants’ LARs who are directing services and supports include:

- The individual or LAR, as the employer, may appoint an adult as a DR to assist in meeting employer responsibilities to the extent directed by the employer;
- The individual’s service coordinator provides information about the CDS option and monitors service delivery through the option. The case management functions provided by service coordinators are more global than those of the Support Advisor and apply to self-directed as well as agency-directed waiver services and non-waiver services. Support Consultation is specific to the individual’s responsibilities as an employer and successful participation in the CDS option.
- A third-party entity, a CDSA, chosen by the individual or LAR, provides FMS. The CDSA holds a Medicaid provider agreement (contract) with DADS.
- The participant employer has the option to receive Support Consultation from a certified Support Advisor of his choice, when authorized in the individual’s service plan, to assist in learning and performing employer responsibilities.

To participate in the CDS option, an individual or LAR must:

- Select a CDSA;
- Participate in orientation and ongoing training conducted by the CDSA;
- Perform all employer tasks that are required for self-direction or designate DR capable of performing these tasks on the individual’s behalf; and
- Maintain a service backup plan for provision of services determined by the service planning team to be critical to the individual’s health and welfare.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

<input type="radio"/>	Participant – Employer Authority. As specified in <i>Appendix E-2, Item a</i> , 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.
<input type="radio"/>	Participant – Budget Authority. As specified in <i>Appendix E-2, Item b</i> , 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.
<input checked="" type="radio"/>	Both Authorities. The waiver provides for both participant direction opportunities as

State:	TEXAS #0403
Effective Date	March 1, 2007

	specified in Appendix E-2 . Supports and protections are available for participants who exercise these authorities.
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c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

<input checked="" type="checkbox"/>	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
<input type="checkbox"/>	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.
<input type="checkbox"/>	The participant direction opportunities are available to persons in the following other living arrangements (<i>specify</i>):

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

<input type="checkbox"/>	Waiver is designed to support only individuals who want to direct their services.
<input checked="" type="checkbox"/>	The waiver is designed to afford every participant (or the participant’s representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="checkbox"/>	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. <i>Specify the criteria:</i>

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.

At the time the CDS option is implemented in the program, DADS will arrange for each eligible individual and LAR to receive information and be provided the opportunity to participate in the option at the time of the annual review of the individual’s service plan or earlier if requested by the individual or LAR. After implementation of the option when an individual enrolls in the waiver, a service coordinator of the local MRA provides the individual and LAR with a written and oral explanation of the CDS option. The information and the opportunity to participate in CDS are presented initially and at least annually to the individual or the LAR, and is also provided at any time on request of the individual or the LAR.

Each individual or LAR is provided information sufficient to assure informed decision-making and understanding of the CDS 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 CDS option.

Information provided orally and in writing to the individual and the legally authorized representative (LAR) by the service coordinator includes:

- An overview of the CDS option;
- Explanation of responsibilities in the CDS option for the individual or individual’s LAR, service coordinator, the CDSA, and a Support Advisor;

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix E: Participant Direction of Services
 HCBS Waiver Application Version 3.3 – October 2005

- Explanation of benefits and risks of participating in the CDS option;
- Self-assessment for participation in the CDS option;
- Explanation of required minimum qualifications of service providers through the CDS option; and
- Explanation of employee/employer relationships that prohibit employment under the CDS option.

f. Participant Direction by a Representative. Specify the State’s policy concerning the direction of waiver services by a representative (*select one*):

<input type="radio"/>	The State does not provide for the direction of waiver services by a representative.
<input checked="" type="radio"/>	The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: (<i>check each that applies</i>):
<input checked="" type="checkbox"/>	A legal representative of the participant may direct waiver services.
<input checked="" type="checkbox"/>	A non-legal representative freely chosen by an adult participant may direct waiver services. 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 LAR may appoint a non-legal representative adult as a DR to assist in performance of employer responsibilities to the extent desired by the individual or LAR. Neither the DR nor the spouse of the DR, may be employed or receive compensation or be the provider of waiver services for the individual.

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-3. (*Check the opportunity or opportunities available for each service*):

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Community Support	X	X
Nursing	X	X
Respite	X	X
Specialized Therapies	X	X
Day Habilitation	X	X
Behavioral Support	X	X
Employment Assistance	X	X
Dental Treatment	X	X
Supported Employment	X	X
Minor Home Modifications	X	X
Adaptive Aids	X	X
Support Consultation Services	X	X

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*:

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix E: Participant Direction of Services
 HCBS Waiver Application Version 3.3 – October 2005

<input checked="" type="radio"/>	Yes. Financial Management Services are furnished through a third party entity. <i>(Complete item E-1-i).</i> Specify whether governmental and/or private entities furnish these services. <i>Check each that applies:</i>
<input checked="" type="checkbox"/>	Governmental entities
<input checked="" type="checkbox"/>	Private entities
<input type="radio"/>	No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. <i>Do not complete Item E-1-i.</i>

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

<input checked="" type="radio"/>	FMS are covered as the waiver service entitled Financial Management Service as specified in Appendix C-3.
<input type="radio"/>	FMS are provided as an administrative activity. <i>Provide the following information:</i>
<input type="checkbox"/>	i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:
<input type="checkbox"/>	ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:
<input type="checkbox"/>	iii. Scope of FMS. Specify the scope of the supports that FMS entities provide <i>(check each that applies):</i>
	<i>Supports furnished when the participant is the employer of direct support workers:</i>
<input type="checkbox"/>	Assist participant in verifying support worker citizenship status
<input type="checkbox"/>	Collect and process timesheets of support workers
<input type="checkbox"/>	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
<input type="checkbox"/>	Other <i>(specify):</i>
	<i>Supports furnished when the participant exercises budget authority:</i>
<input type="checkbox"/>	Maintain a separate account for each participant's participant-directed budget
<input type="checkbox"/>	Track and report participant funds, disbursements and the balance-of participant funds
<input type="checkbox"/>	Process and pay invoices for goods and services approved in the service plan
<input type="checkbox"/>	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
<input type="checkbox"/>	Other services and supports <i>(specify):</i>
	<i>Additional functions/activities:</i>
<input type="checkbox"/>	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
<input type="checkbox"/>	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix E: Participant Direction of Services
 HCBS Waiver Application Version 3.3 – October 2005

	<input type="checkbox"/>	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
	<input type="checkbox"/>	Other (<i>specify</i>):
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.

State:	TEXAS #0403
Effective Date	March 1, 2007

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*):

<input type="checkbox"/>	Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. <i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:</i>
<input checked="" type="checkbox"/>	Waiver Service Coverage. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled: Financial Management Services (FMS) provided by a CDSA, a required service for participation in the CDS option, and Support Consultation provided by a Support Advisor as an optional service to support participant direction.
<input type="checkbox"/>	Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity. <i>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:</i>

k. Independent Advocacy (*select one*).

<input type="radio"/>	Yes. Independent advocacy is available to participants who direct their services. <i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i>
<input checked="" type="radio"/>	No. Arrangements have not been made for independent advocacy.

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 LAR may voluntarily terminate participation in the CDS option at anytime. The individual's service coordinator assists the individual in revising the individual's service plan for the transition of services previously delivered through the CDS option to be delivered by the TxHmL program provider chosen by the individual or LAR. The CDSA 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.

State:	TEXAS #0403
Effective Date	March 1, 2007

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Involuntary termination of the CDS option may occur when:

- The individual’s service planning team, in conjunction with the CDSA or DADS staff, determines that continued participation in the CDS option would not permit the individual’s health and welfare needs to be met; or
- The individual’s service planning team, in conjunction with the CDSA, or DADS staff determines that the individual or the individual’s representative, when provided with additional support from the CDSA or through Support Consultation, has not carried out employer responsibilities in accordance with requirements of the option.

The individual’s service coordinator and service planning team assist the individual to ensure continuity of all waiver services through the traditional agency service delivery option (provider-managed service delivery) and maintenance of the individual’s health and welfare during the transition from the CDS option. The CDSA 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.

n. Goals for Participant Direction. In the following table, provide the State’s goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n		
	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		414
Year 2		615
Year 3		850
Year 4 (renewal only)		850
Year 5 (renewal only)		850

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix E-2: Opportunities for Participant-Direction

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. Check each that applies:

<input type="checkbox"/>	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. <i>Specify the types of agencies (a.k.a., “agencies with choice”) that serve as co-employers of participant-selected staff:</i>
<input checked="" type="checkbox"/>	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. Check the decision making authorities that participants exercise:

<input checked="" type="checkbox"/>	Recruit staff
<input type="checkbox"/>	Refer staff to agency for hiring (co-employer)
<input type="checkbox"/>	Select staff from worker registry
<input checked="" type="checkbox"/>	Hire staff (common law employer)
<input checked="" type="checkbox"/>	Verify staff qualifications
<input checked="" type="checkbox"/>	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated: Funds available in the individual’s CDS budget are used for this purpose.
<input checked="" type="checkbox"/>	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
<input checked="" type="checkbox"/>	Determine staff duties consistent with the service specifications in Appendix C-3.
<input checked="" type="checkbox"/>	Determine staff wages and benefits subject to applicable State limits
<input checked="" type="checkbox"/>	Schedule staff
<input checked="" type="checkbox"/>	Orient and instruct-staff in duties
<input checked="" type="checkbox"/>	Supervise staff
<input checked="" type="checkbox"/>	Evaluate staff performance
<input checked="" type="checkbox"/>	Verify time worked by staff and approve time sheets
<input checked="" type="checkbox"/>	Discharge staff (common law employer)
<input type="checkbox"/>	Discharge staff from providing services (co-employer)
<input type="checkbox"/>	Other (specify):

State:	TEXAS #0403
Effective Date	March 1, 2007

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. *Check all that apply:*

<input checked="" type="checkbox"/>	Reallocate funds among services included in the budget
<input checked="" type="checkbox"/>	Determine the amount paid for services within the State’s established limits
<input checked="" type="checkbox"/>	Substitute service providers
<input checked="" type="checkbox"/>	Schedule the provision of services
<input checked="" type="checkbox"/>	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3.
<input checked="" type="checkbox"/>	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
<input checked="" type="checkbox"/>	Identify service providers and refer for provider enrollment
<input checked="" type="checkbox"/>	Authorize payment for waiver goods and services
<input checked="" type="checkbox"/>	Review and approve provider invoices for services rendered
<input type="checkbox"/>	Other (<i>specify</i>):

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 amount of funds included in an individual service plan is calculated by the individual’s service planning team based on the planned waiver services and the adopted reimbursement rate. The service plan, based on the PDP, is developed in the same manner for the participant who elects the CDS option as it is for the participant who elects to have services delivered through the traditional provider-managed option. **The individual service plan and the estimated cost of waiver services must be authorized by DADS. The participant-directed budget is composed of those authorized services and estimated costs that will be directed by the individual and itemized in the individual service plan authorized by DADS.**

The amount of funds included in the service plan for each service component to be self-directed is budgeted by the individual or LAR with assistance from the CDSA. The budget for each service component, and any revisions, must be approved by the CDSA prior to implementation. The CDSA must ensure that projected expenditures are within State set spending limits, 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 CDSA, the individual or LAR may make revisions to a specific service budget that does 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 individual’s service planning team and authorized by DADS. With assistance of the CDSA, the individual or LAR revises the CDS budget to reflect a revision in the service plan.

State:	TEXAS #0403
Effective Date	March 1, 2007

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 LAR participates as a member of the service planning team that develops the individual's PDP upon which the service plan is based. The team develops the service plan and service plan in the same manner as it does for an individual electing provider-managed services.

On completion of the service plan, the individual or LAR is notified of the amount of funds allocated to each service component to be self-directed through the CDS option during the service planning team meeting. The service coordinator informs the individual or LAR of procedures to request a revision to the service plan.

An individual whose request for an adjustment to his/her participant-directed budget is denied is entitled to a fair hearing in accordance 1 TAC Part 15, Chapter 357, Subchapter A. DADS must send written notification to the participant or legally authorized representative (LAR), indicating the reason for the denial, the participant's right to a fair hearing and the process the participant must follow to request a fair hearing.

iv. Participant Exercise of Budget Flexibility. *Select one:*

<input checked="" type="radio"/>	<p>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:</p> <p>The individual or LAR has the authority to modify the budget for a specific service component to be provided through CDS without prior approval of DADS when DADS has authorized the individual service plan. Within a specific service component budget, the individual or LAR must obtain approval from the CDSA prior to implementation of the change. The budget is updated to reflect the change and the effective date of the change.</p> <p>The individual's service planning team must justify and recommend revisions to an individual's service plan. That change, when authorized by DADS, is then reflected in a revised participant-directed service budget as applicable to the service. The budget is updated to reflect the change and the effective date of the change.</p>
<input type="radio"/>	<p>Modifications to the participant-directed budget must be preceded by a change in the service plan.</p>

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 CDS budget is calculated and monitored based on projected utilization and frequency of the service as determined by the service planning team. The CDSA is required to monitor payroll every pay period (2 weeks) and expenditures (as processed for payment) and report over- and under-utilization to the employer and the service coordinator. When an over- or under-utilization is not corrected by the individual or LAR, the CDSA notifies the individual's service coordinator and the employer. The service coordinator and the individual identify the cause of continuing deviation from projected utilization and develop a plan to correct the

State:	TEXAS #0403
Effective Date	March 1, 2007

deviation or revise the service plan.

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

An applicant whose request for eligibility for the waiver program is denied or is not acted upon with reasonable promptness, or an individual whose TxHmL Program services have been terminated, suspended, or reduced by DADS, is entitled to a fair hearing in accordance with 1 TAC Part 15, Chapter 357, Subchapter A. DADS sends written notification to the individual or LAR, indicating the individual's right to a fair hearing and the process to follow to request a fair hearing. **Fair Hearings are conducted by HHSC, the State Medicaid Agency.**

An opportunity for a fair hearing under 42 CFR 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 the institutional care or who are denied the service(s) of their choice, or the provider(s) of their choice.

During the enrollment process, an applicant's service coordinator informs the applicant or the applicant's LAR of the applicant's right to a fair hearing.

DADS retains in an applicant's or participant's record a copy of the notice of adverse action taken by DADS and the notice to the participant or applicant of the opportunity to request a Fair Hearing. The notice informs a participant whether or not he is eligible to receive or continue to receive services while the participant's appeal is under consideration and the actions that the participant must take in order for current services to continue. If an applicant or participant or his authorized representative elects to request a Fair Hearing, a copy of the applicant's/participant's written request for a hearing is retained in the participant's record.

State:	TEXAS #0403
Effective Date	March 1, 2007

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:*

<input type="radio"/>	Yes. The State operates an additional dispute resolution process (<i>complete Item b</i>)
<input checked="" type="radio"/>	No. This Appendix does not apply (<i>do not complete Item b</i>)

- 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.

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State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

<input checked="" type="checkbox"/>	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 (<i>complete the remaining items</i>).
<input type="checkbox"/>	No. This Appendix does not apply (<i>do not complete the remaining items</i>)

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The state agencies that operate the grievance/complaint system are DADS, the operating agency, and HHSC, the state Medicaid agency.

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).

<p>DADS staff receives complaints from applicants seeking enrollment or individuals enrolled in the TxHmL Program or their families and representatives. DADS staff advises complainants that the formal filing of a complaint is not a substitute or required in order for the recipient to request a fair hearing if enrollment or services are denied or suspended. At the time of a recipient's enrollment in TxHmL Program, the recipient's MRA Service coordinator also advises him or her that the recipient's filing of a complaint is not pre-requisite or substitute for requesting a fair hearing.</p> <p>Grievances or complaints can be submitted by telephone by calling a toll-free line, by e-mail, or by written correspondence. In-office employees answer the toll-free line from 8 a.m. to 5 p.m. Monday through Friday. Voice mail is available 24 hours a day and is monitored by in-office employees from 8 a.m. to 5 p.m. on Saturday, Sunday, and holidays. Complaints may be anonymous. The identity of all complainants and consumers is protected by law. Consumer Rights and Services (CRS) staff investigates the complaint and attempt resolution within fourteen days of the initiation of the investigation, unless the complaint involves abuse, neglect, or exploitation of an individual receiving services. Complaints involving allegations of abuse, neglect, or exploitation are referred immediately to the Texas Department of Family and Protective Services (DFPS), the agency with statutory responsibility for investigation of such allegations. Resolution of complaints not referred to DFPS are tracked and recorded in the CRS complaint database. The status of all complaints unresolved in 90 days are documented in follow-up letters to the complainant unless doing so places him/her in jeopardy.</p> <p>Created by the 78th Texas Legislature, HHSC's 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's services include:</p> <ul style="list-style-type: none"> Conducting independent reviews of complaints concerning agency policies or practices; Ensuring policies and practices are consistent with the goals of HHSC; Ensuring individuals are treated fairly, respectfully and with dignity; and Making referrals to other agencies as appropriate <p>The process to assist with complaints and issues is as follows:</p> <ol style="list-style-type: none"> 1. Member of the public, individual, or provider makes first contact with HHSC or with DADS to request assistance with an issue or complaint. 2. If not able to resolve the issue or complaint, the Office of the Ombudsman may be contacted.
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State:	TEXAS #0403
Effective Date	March 1, 2007

3. The Office of the Ombudsman will provide an impartial review of actions taken by the program or department.
4. The Office of the Ombudsman will seek a resolution and may use mediation if appropriate. 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:
 - o Follow-up with the complainant to determine if a resolution has been achieved.
 - o Refer complainant to other available known resources.

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All program provider personnel, individuals and LARs and CDSAs are provided the Texas Department of Family and Protective Services (TDFPS) toll-free telephone number in writing and are instructed to report to TDFPS immediately, but not later than one hour after having knowledge or suspicion, that an individual has been or is being abused, neglected, or exploited.

The program provider must report the death of participant to the local MRA and DADS by the end of the next business day following the death of the individual or the program provider's knowledge of the death and, if the program provider reasonably believes that the participant's LAR or family does not know of the participant's death, to the individual's LAR or family as soon as possible, but not later than 24 hours after the program provider learns of the individual's death.

On a monthly basis, TxHmL Program providers are required to enter any of the following critical incidents that occurred during the preceding month in the automated Critical Incident Reporting System.

- Medication errors committed by program provider staff or occurring under the supervision of program provider staff;
- Serious physical injuries;
- Deaths;
- Number of behavior intervention plans authorizing use of restraint;
- Number of individuals enrolled in the provider's program that required use of emergency restraints (i.e., restraints not authorized in a behavior intervention program); and
- Number and type of emergency restraints (personal, mechanical and chemical) used.

- b. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

At the time an individual is enrolled in TxHmL or at the time an individual's legal status changes, an MRA must assure that an individual and LAR is informed orally and in writing of the processes for reporting allegations of abuse, neglect or exploitation. The toll free number for TDFPS must be provided.

A program provider must, at the time an individual is enrolled or at the time an individual's legal status changes, assure that the individual and the LAR are informed of how to report allegations of abuse, neglect, or exploitation to TDFPS and are provided with the TDFPS toll-free telephone number in writing.

State:	TEXAS #0403
Effective Date	March 1, 2007

Evidence support compliance with these requirements is review during DADS’s annual on-site monitoring review of the MRA or the program provider.

In addition to information provided to all individuals in the waiver, the CDSA provides individuals electing the CDS option, the individual’s LAR and, if applicable, the DR training and written information related to reporting allegations of abuse, neglect, and exploitation.

- c. 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 Texas Department of Family and Protective Services (DFPS) receives allegations of abuse, neglect and exploitation (ANE) of individuals enrolled in the TxHmL Program and is statutorily responsible for review, investigation and response to those reports. Depending on the severity of the allegation, DFPS investigations must be completed with 14 to 21 days. DADS receives monthly reports of all other critical incidents directly from program providers. DADS also receives reports of participant deaths directly from program provider within one business day of the death.

In accordance with rules governing the operation of the TxHmL Program, a participant’s program provider must inform the participant and LAR of the findings of the investigation no later than five calendar days from the program provider’s receipt of the investigation report, the corrective action taken by the program provider if DFPS confirms that abuse, neglect, or exploitation occurred, the process to appeal the investigation finding, and the process for requesting a copy of the investigative report.

- d. 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.

DFPS forwards to DADS a report of each of its investigations along with its determination that the allegation was confirmed or not confirmed or that results of the investigation were inconclusive. DADS reviews all investigation reports completed by DFPS. Based on the content of the report, DADS may conduct an on-site review 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 ANE database by DADS staff. DADS also records deaths in a database. Reports of critical incidents are compiled on a monthly basis for each program provider. In preparation for annual and some intermittent certification reviews of providers, DADS staff compiles data related to all critical incidents reported by or involving the program provider. The information may be used in selecting the sample of individuals whose records will be reviewed and who may be interviewed during the certification review and to ensure appropriate follow-up was conducted by the program provider.

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

This Appendix must be completed when the use of restraints and/or restrictive interventions is permitted during the course of the provision of waiver services regardless of setting. When a state prohibits the use of restraints and/or restrictive interventions during the provision of waiver services, this Appendix does not need to be completed.

a. Applicability. Select one:

<input type="radio"/>	This Appendix is not applicable. The State does not permit or prohibits the use of restraints or restrictive interventions (<i>do not complete the remaining items</i>)
<input checked="" type="radio"/>	This Appendix applies. Check each that applies:
<input checked="" type="checkbox"/>	The use of personal restraints, drugs used as restraints, mechanical restraints and/or seclusion is permitted subject to State safeguards concerning their use. <i>Complete item G-2-b.</i>
<input checked="" type="checkbox"/>	Services furnished to waiver participants may include the use of restrictive interventions subject to State safeguards concerning their use. <i>Complete items G-2-c.</i>

b. Safeguards Concerning Use of Restraints or Seclusion

- 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).

In addition to requiring program providers to report the use of emergency restraints, the rules governing the TxHmL Program also require the program provider’s compliance with certification principles prohibiting the use of unnecessary restraints during the provision of waiver services. In the event an emergency restraint is used, the program provider must report to the individual’s service coordinator that changes may be needed to the individual’s PDP or service plan. If restrictive or intrusive techniques, including restraint, are used as part of a behavioral support plan, **the provider and service coordinator must assure that alternative methods to avoid the use of restraint or seclusion have been attempted and have failed before authorizing the use of restraint or seclusion as an intervention** and the program provider must assure that the implementation of such techniques includes:

- Approval by the individual's service planning team;
- Written consent of the individual or LAR;
- Verbal and written notification to the individual or LAR of the right to discontinue participation in the behavioral support plan at any time;
- Assessment of the individual's needs and current level/severity of the behavior(s) targeted by the plan;
- Use of techniques appropriate to the level/severity of the behavior(s) targeted by the plan;
- A written behavior support plan developed by a psychologist or behavior analyst with input from the individual, LAR, the individual's service planning team, and other professional personnel;
- Collection and monitoring of behavioral data concerning the targeted behavior(s);
- Allowance for the decrease in the use of intervention techniques based on behavioral data;
- Allowance for revision of the behavioral support plan when desired behavior(s) are not displayed or techniques are not effective;
- Consideration of the effects of the techniques in relation to the individual's physical and

State:	TEXAS #0403
Effective Date	March 1, 2007

psychological well-being; and

At least annual review by the individual's service planning team to determine the effectiveness of the program and the need to continue the techniques.

Program provider personnel who are involved in the administration of restraint or seclusion must receive initial and periodic training in the safe use of the specific intervention, when the intervention should be used, and criteria for discontinuing the intervention.

Certification principles also require provider personnel to report abuse, neglect, or exploitation within 1 hour of the incident.

Program providers must demonstrate compliance with these principles during annual on-site certification reviews conducted by DADS.

Complaints concerning unnecessary/unapproved use of restraint can be made to the local MRA, DADS, or DFPS. The MRA must assure that an individual or LAR is informed orally and in writing of the processes for filing complaints about the provision of TxHmL Program services including:

- (A) the telephone number of the MRA to file a complaint;
- (B) the toll-free telephone number of DADS Consumer Rights and Services to file a complaint; and
- (C) the toll-free telephone number of DFPS to file a complaint of abuse, neglect, or exploitation.

- 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:

DADS completes program provider reviews on an annual basis and in response to unresolved complaints or indications of misuse of restraints documented in DFPS investigative findings. Deficiencies related to misuse of restraint or seclusion observed during on-site provider reviews are entered into the DADS CARE System. Quarterly reports allow DADS staff to identify trends or patterns across the provider-base as well as trends or patterns in the performance of an individual provider agency. This information is used to guide the development of provider training and also guide certification review staff in providing technical assistance to provider agencies in developing systemic corrections to their operations.

c. **Safeguards Concerning the Use of Restrictive Interventions**

- 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.

When a behavioral support plan includes techniques that involve restriction of individual rights or intrusive techniques, including restraints, **the program provider and service coordinator must assure that alternative methods to avoid the use of restrictive interventions have been attempted and have failed before authorizing the use of restraint or seclusion as an intervention.** Additionally, the program provider must assure that the implementation of such techniques includes:

State:	TEXAS #0403
Effective Date	March 1, 2007

- (A) Approval by the individual's service planning team;
- (B) Written consent of the individual or LAR;
- (C) Verbal and written notification to the individual or LAR of the right to discontinue participation in the behavioral support plan at any time;
- (D) Assessment of the individual's needs and current level/severity of the behavior(s) targeted by the plan;
- (E) Use of techniques appropriate to the level/severity of the behavior(s) targeted by the plan;
- (F) A written behavior support plan developed by a psychologist or behavior analyst with input from the individual, the individual's LAR, the individual's service planning team, and other professional personnel;
- (G) Collection and monitoring of behavioral data concerning the targeted behavior(s);
- (H) Allowance for the decrease in the use of intervention techniques based on behavioral data;
- (I) Allowance for revision of the behavioral support plan when desired behavior(s) are not displayed or techniques are not effective;
- (J) Consideration of the effects of the techniques in relation to the individual's physical and psychological well-being; and
- (K) At least annual review by the individual's service planning team to determine the effectiveness of the program and the need to continue the techniques.

Any restrictive intervention must be appropriate to the current frequency or severity of the behavior displayed by a participant. Restrictive interventions that would be permitted include restricting privileges such as having access to recreational activities, access to other participants, or certain locations. Interventions that are not permitted include restrictions that endanger health or welfare or prevent access to basic human necessities such as food or water. Restrictive interventions are only allowed when a behavioral support plan that meets the above criteria is in place.

Program provider personnel who are involved in the administration of a behavioral support plan utilizing a restrictive intervention must receive initial and periodic training in the safe use of the specific intervention, when the intervention should be used, and criteria for discontinuing the intervention.

Complaints concerning unnecessary/unapproved restriction of rights can be made to the local MRA, DADS, or DFPS. The MRA must assure that an individual or LAR is informed orally and in writing of the processes for filing complaints about the provision of TxHmL Program services including:

The telephone number of the MRA to file a complaint;

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

and

The toll-free telephone number of TDFPS 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 completes certification reviews of each program provider on an annual basis and in response to unresolved complaints indicating unnecessary/unapproved restriction of rights documented in DFPS investigative findings.

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix G-3: Medication Management and Administration

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:

<input type="radio"/>	Yes. This Appendix applies (<i>complete the remaining items</i>).
<input checked="" type="radio"/>	No. This Appendix is not applicable (<i>do not complete the remaining items</i>).

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.

c. Medication Administration by Waiver Providers

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

<input type="radio"/>	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. (<i>complete the remaining items</i>)
<input type="radio"/>	Not applicable (<i>do not complete the remaining items</i>)

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).

State:	TEXAS #0403
Effective Date	March 1, 2007

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

<input type="radio"/>	Providers that are responsible for medication administration are required to <i>both</i> record and report medication errors to a State agency (or agencies). <i>Complete the following three items:</i>
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to <i>record</i> :
	(c) Specify the types of medication errors that providers must <i>report</i> to the State:
<input type="radio"/>	Providers responsible for medication administration are required to <i>record</i> 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:

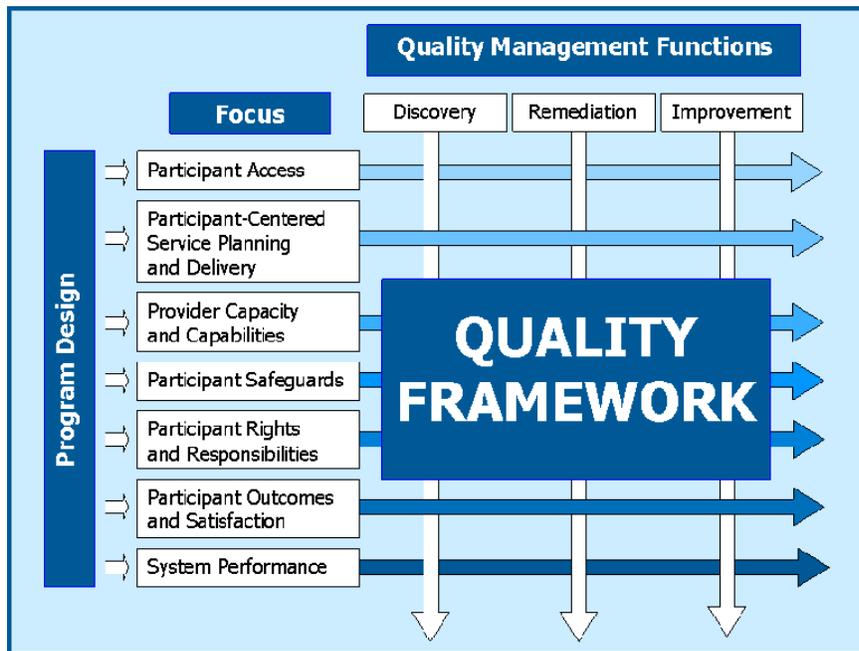
iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

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State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix H: Quality Management Strategy

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 Management 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. A Quality Management Strategy explicitly describes the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state’s waiver Quality Management 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 Management 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 Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

State:	TEXAS #0403
Effective Date	March 1, 2007

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

1. **The Quality Management Strategy must describe how the state will determine that each waiver assurance and requirement is met.** The applicable assurances and requirements are: (a) level of care determination; (b) service plan; (c) qualified providers; (d) health and welfare; (e) administrative authority; and, (f) financial accountability. For each waiver assurance, this description must include:

- Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices A, B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
- The entities or individuals responsible for conducting the discovery/monitoring processes;
- The types of information used to measure performance; and,
- The frequency with which performance is measured.

2. **The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants, advocates, and service providers.**

Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.

3. **Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.** *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in # 2 above.*

4. **The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public.** *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*

5. **The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy.**

If the State's Quality Management 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 Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix H: Quality Management Strategy
HCBS Waiver Application Version 3.3 – October 2005

When the Quality Management 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 identify the other long-term services that are addressed in the Quality Management Strategy.

State:	TEXAS #0403
Effective Date	March 1, 2007

Attachment #1 to Appendix H

The primary objective of the Quality Management Plan (QMP) is to administer and measure a quality system that: 1) ensures that the State meets each of the six required CMS assurances; 2) identifies and acts on opportunities for improvement; and 3) reflects values and principles common across all of DADS programs. The DADS QMP is dynamic in order to respond continually to findings and conditions related to participants, programs, providers, and administration of DADS programs. The Quality Management Plan is based on discovery, remediation, improvement, evidence-based best practices, and education.

Quality measurement activities are often the same across all DADS HCBS waivers, however, certain differences must be taken into account each waiver associated with the populations and types of services offered. Because of the size and scope of DADS programs, the QMP will have sections devoted to specific programs. The Quality Management Strategy for the TxHmL Program, as well as the other HCBS waivers operated by DADS, will have its own section in the DADS Quality Management Plan and address outcomes and indicators specific to that waiver program or service. This appendix represents the TxHmL Program section of the DADS QMP. As detailed later in this appendix, the DADS QMP will include stakeholder involvement in evaluating information identified in the discovery process and assist in developing strategies for remediation and improvement.

QMP Element H1: **Waiver Assurances, Discovery Tools, Methods and Findings**

This appendix details the discovery processes, entities responsible, frequency of process, data and type of information used, and any reports generated in order to ensure compliance with each requirement of the following assurances in the TxHmL Program:

- (A) Level of Care Determinations and Re-evaluations
- (B) Service Plan
- (C) Qualified Providers
- (D) Health and Welfare
- (E) Administrative Authority
- (F) Financial Accountability

DADS has implemented a comprehensive process for managing the operation of the TxHmL Program and identifying issues or problems with its operation. In the subsequent QMP matrix, the following discovery methods will be referenced.

CARE System. DADS uses the Client Assignment and Registration System (the CARE System mainframe computer) to collect, process, and report information about the waiver. A wide variety of management reports can be generated from this system. The CARE System maintains the following information:

- Applicant and Participant Information. The CARE System includes information about applicants and individuals who are enrolled, including level of care determinations and individual service plans as well as subsequent re-determinations, plan revisions and renewals.

State:	TEXAS #0403
Effective Date	March 1, 2007

- TxHmL Program Provider Information. The CARE System records and stores program provider information, including the date of the original program provider agreement, Texas counties served by each program provider, number of individuals enrolled with each program provider, and results of on-site certification reviews (e.g., type of sanction imposed, if applicable), and all citations of non-compliance associated with each on-site review.
- Critical Incident Reporting System. This CARE subsystem requires program providers participating in the TxHmL Program to report specific critical incidents as specified in Appendix G-1.
- Billing and Payment Information. The CARE System also provides a mechanism for program providers and CDSAs to electronically submit records of service delivery and claims for reimbursement for those services.

On-site Program Provider Reviews. DADS’ staff conduct at least annual on-site reviews of each waiver provider to evaluate compliance with the 49 provider certification principles set forth in state rules at 40 TAC, Part 1, Chapter 9, Subchapter N. Intermittent reviews are also conducted if a pattern of unresolved complaints or critical incidents is detected or if a provider’s past TxHmL Program performance or performance under other provider agreements/contracts with DADS warrants more frequent review.

In preparation for on-site provider reviews, team members:

- Select a cross-section of individuals based on content of individual service plans and individuals’ behavioral, functional, or medical characteristics;
- Retrieve information pertinent to the program provider’s operation from a database containing results of investigations of allegations of abuse, neglect, and exploitation (ANE database) and a database of complaints received by the DADS Consumer Rights and Services Unit that reflect a providers potential non-compliance with certification principles;
- Review results of the provider’s past performance during on-site reviews;
- **Review** critical incident statistics as retained in the CARE System; and
- Notations concerning the provider’s performance that were observed during on-site reviews of MRAs as retained in the CARE System.

While on-site, review team members gather evidence of a program provider’s compliance with the provider certification principles through:

- Interviews with individuals and their families or representatives;
- Interviews with direct service providers;
- Observation of service delivery;
- Reviews of individuals’ records; and
- **Review of personnel records to verify minimum provider qualifications are met.**

Results of each on-site review are documented in the CARE System.

On-site MRA Reviews. DADS staff conduct at least annual on-site reviews of each MRA serving individuals enrolled in the TxHmL Program to evaluate the MRA’s compliance with program principles for MRAs set forth in state rules at 40 TAC Part 1, Chapter 9, Subchapter N.

State:	TEXAS #0403
Effective Date	March 1, 2007

In preparation for on-site MRA reviews, review team members select a cross-section of individuals served by various program providers operating in the MRA’s service area. In addition, team members retrieve from the CARE System notations concerning the MRA’s performance that were observed during on-site reviews of program providers operating in the MRA’s service area.

Review team members gather evidence of an MRA’s compliance with the 16 program principles for MRAs through:

- Interviews with individuals and their families or representatives;
- Interviews with direct service providers; and
- Reviews of individuals’ records.

On-site Consumer Directed Services Agency (CDSA) Reviews. DADS staff conduct at least bi-annual on-site reviews of each CDSA serving individuals enrolled in the TxHmL Program to evaluate the CDSA’s compliance with contracting requirements set forth in the provider agreement and in state rules at 40 TAC, Part 1, Chapter 49, Contracting for Community Care Services and with program requirements set forth in state rules at 40 TAC, Part 1, Chapter 41, Consumer Directed Services. (Chapter 41 has been rewritten and will be effective prior to the effective date of this renewal).

Review team members gather evidence of a CDSA’s compliance through:

- Interviews with individuals and their families or representatives;
- Reviews of individuals records; and
- Reviews of CDSA and financial records

On-site Billing and Payment Reviews. The billing and review process, the fiscal monitoring process used by DADS, is described in Appendix I-1. Results of each on-site billing and payment review are documented in a written report that itemizes each claim found in error. These reports are maintained both electronically and in a manual filing system. A summary of each review, including the name of the provider, the dollar amount to be subtracted from the pending or future payments to the provider, if applicable, and the date all claims adjustments are finalized is maintained in an Excel spreadsheet.

Desk Reviews. DADS’ staff conduct prior authorization desk reviews of all requests by program providers to provide adaptive aids, minor home modifications, or dental treatment. DADS’ staff authorize or deny such requests in the CARE System. Program providers are unable to submit claims for these service components until DADS staff has authorized the specific request.

Consumer Rights and Service (CRS) Complaint Data Base. DADS staff receives complaints from applicants to, or individuals enrolled in, the TxHmL Program or their families and representatives. CRS staff investigate the complaint and attempt resolution of it unless the complaint involves abuse, neglect, or exploitation of an individual receiving services. Complaints involving allegations of abuse, neglect, or exploitation are referred immediately to the Texas Department of Family and Protective Services (DFPS), the agency with statutory responsibility for investigation of such allegations. Resolution of complaints not referred to DFPS are tracked and recorded in the CRS Complaint Data Base.

Allegations of Abuse, Neglect, and Exploitation (ANE) Review. DFPS provides DADS copies of each investigation of ANE involving an individual enrolled in the TxHmL Program regardless of the investigation findings (e.g., confirmed, not confirmed, inconclusive). Based on the

State:	TEXAS #0403
Effective Date	March 1, 2007

content of the DFPS report, DADS staff may conduct an on-site review of the provider or require the provider to submit evidence of follow up action on the incident.

Investigations of Abuse, Neglect and Exploitation (ANE) Data Base. Information regarding DFPS findings and DADS follow up on those findings is entered into the ANE database by DADS staff responsible for oversight of TxHmL Program providers’ compliance with certification principles for program providers.

National Core Indicators (NCI) Face-to-Face Interviews. As a result of activities occurring under a Real Choice Systems Change grant, DADS has joined the NCI Project. The grant’s task force is composed of individuals enrolled in services, family members, Mental Retardation Authority staff, advocacy groups, and representatives of provider organizations. The group determined that the NCI tool was the most useful tool for evaluating individual experience in the TxHmL Program.

The National Core Indicators and the Texas specific performance indicators include approximately 100 consumer, family, systemic, cost, and health and safety indicators. Together these indicators will lead to understanding the overall effectiveness of DADS’ developmental disabilities programs and services.

Associated with each indicator is a source from which the data is collected. Sources of information include:

- Consumer survey (e.g., empowerment and choice issues);
- Family surveys (e.g., satisfaction with supports); and
- CARE system

QMP Element H2: Roles and Responsibilities

DADS is in the process of designing a centralized quality assurance/quality improvement system, incorporating person-directed planning, consumer choice and control, where appropriate, and outcome-based evaluation mechanisms across all program services. The Quality Assurance and Improvement Unit (QAI) of the Center for Policy and Innovation (CPI) was created by DADS to assist other entities with the development, tracking and reporting of quality improvement initiatives to successfully achieve this goal.

DADS Regulatory Services (RS), Provider Services (PS), and Access and Intake (A&I) divisions have collaborated to develop the QMP for the TxHmL program and will provide certification, investigation, and contract monitoring of the entities providing long term services and supports to individuals receiving services through the TxHmL program. As detailed in the attached QMP matrix, these organizational areas will continue to assist with the previously mentioned discovery activities as well as in the remediation, improvement, and evaluation processes.

DADS’ plans to create a Virtual Quality Consortium (VQC) comprised of internal and external stakeholders. Internal stakeholders will consist of representatives from the Texas Health and Human Services Commission (HHSC), the State Medicaid Agency, and subject matter experts from each of DADS business units (Access and Intake, Provider Services, Regulatory Services, Consumer Rights and Services, Budget, and the Center for Program Coordination, Center for Consumer and External Affairs, and Center for Policy and Innovation).

State:	TEXAS #0403
Effective Date	March 1, 2007

External stakeholders will include current task force members from previous 2003 Real Choice Systems Change Grants and will encompass a diverse group of constituents. **The consortium members include self-advocates and family members of persons receiving services through the TxHmL program as well as representatives of advocacy groups such as the Arc of Texas and interest groups representing public and private TxHmL program providers.** Many have been actively involved in the quality assurance grant activities and wish to continue partnering with DADS to help sustain grant initiatives. The Virtual Quality Consortium will consist of individuals who receive services, including those who choose to direct their own services. Participant input will be vital in identifying intervention strategies and evaluating the QMP.

The VQC will be a mechanism to provide real time exchange of information and allow consortium members to have ongoing input about quality initiatives. It will allow DADS to provide regular updates, information, data, project status, and quality initiative information to members. It will also be a mechanism for continuous input from stakeholders concerning the effectiveness of the plan, **and the roles consortium members play in implementation of the plan.** It is anticipated that face-to-face meetings of the VQC will be held as needed to allow input from people who do not have access to technology.

QMP Element H3: Processes to Establish Priorities and Development Strategies for Remediation and Improvement

The QMP matrix identifies numerous quality indicators that will be tracked and reported to appropriate program staff on a quarterly basis. DADS will aggregate, verify, analyze, and report the results of the discovery processes to evaluate the goals of the TxHmL quality management strategy. During this evaluation, program staff will identify areas for remediation and improvement and priorities will be established. The remediation and improvement strategies may vary based upon the findings. When areas for improvement are identified, processes will be established to ensure appropriate and timely action is taken. Remediation and improvement strategies could result from any one of the following activities.

Actions based on Results of On-site TxHmL Program Provider Reviews. State rules for the TxHmL Program provide for the following actions based on outcomes of on-site program provider reviews:

- (A) Corrective Action Plan. When a program provider demonstrates compliance with 90 percent or more of the 49 certification principles for program providers, DADS certifies or re-certifies the program provider and requires the provider to submit a corrective action plan to DADS to address any areas of noncompliance discovered. DADS confirms corrective action during the next annual or intermittent on-site review.
- (B) Level 1 Sanction. Program providers demonstrating non-compliance with more than 10 percent of the certification principles must complete corrective action within 30 calendar days after the completion of the DADS on-site review. DADS staff conducts a follow-up review and certifies or re-certifies the program provider if all areas of non-compliance have been corrected. If one or more areas of non-compliance remain uncorrected at the end of the follow-up review, DADS withholds certification and implements a “vendor hold” on all pending payments to the program provider for HCS Program services. DADS conducts a second follow-up review within 45 days of the implementation of a “vendor hold” to determine if areas remaining out of compliance during the first follow-up review have been corrected. DADS certifies or re-certifies the program provider if all corrections have been made but denies certification and initiates termination of the provider’s waiver program provider agreement if an area of non-compliance remains uncorrected at the end of the second follow-up review.
- (C) Level 2 Sanction. Program providers demonstrating non-compliance with more than 20 percent of the certification principles must complete corrective action within 30 calendar days after the on-site review. DADS conducts a follow-up review at the end of the corrective action period to determine if areas of non-compliance have been corrected. DADS certifies or re-certifies the program provider if all corrections

State:	TEXAS #0403
Effective Date	March 1, 2007

have been made but denies certification and initiates termination of the provider’s waiver program provider agreement if an area of non-compliance remains uncorrected at the end of the follow-up review.

(D) **Discretionary Sanctions.** Discretionary sanctions may be imposed for serious or pervasive non-compliance even if the percentage of noncompliance is less than the percentage indicated above for Level 1 or Level 2 sanctions. Immediate denial of certification may occur if individuals’ health and safety are jeopardized as a result of program provider services.

Actions Based on Recommendations to Initiate Provider Sanctions. To ensure consistent application of provider sanctions, the DADS Sanction Action Review Committee must approve vendor holds resulting from discretionary sanctions, denials of certification, and terminations of program provider agreements.

Actions Based on Results of Program Provider Billing and Payment Reviews. If claims submitted by a program provider are found to be in error during a billing and payment review, DADS subtracts the amount of the erroneous claim from pending payments or future payments due the program provider. This action is taken through the CARE System and assures that federal matching funds are claimed appropriately.

Actions based on Results of On-site Reviews of MRAs. DADS requires an MRA to submit a corrective action plan to DADS if, at the end of a review an area of non-compliance remains uncorrected. The corrective action plan must specify actions to be taken by the MRA to correct the area of non-compliance and must be approved by DADS.

DADS may impose sanctions against an MRA that includes requiring the completion of a plan of correction that may include a follow-up on-site review or financial sanctions as provided in the MRA’s performance contract with DADS.

Training and Technical Assistance.

Annual Program Provider Conferences. DADS sponsors an annual training conference for providers of community-based mental retardation services including TxHmL Program providers. The conference topics include presentations on the areas most frequently found to be in non-compliance with program rules during on-site reviews and methods for correcting such areas. Examples of other conference discussion topics include applying principles of person-directed planning, case management/service coordination responsibilities, principles of self-determination, and billing guidelines and documentation requirements.

Technical Assistance. DADS staff routinely provides technical assistance during on-site reviews of program providers to clarify program requirements and offer suggestions for performance or process improvement. DADS staff is available to respond to concerns or questions from individuals or their legally authorized representatives (LAR)/families, program providers, or other stakeholders by telephone or by e-mail.

Monitoring of Level of Care Determinations. DADS implemented a process for supervisory review of a sample of level of care determinations made each quarter by DADS staff.

National Core Indicators Survey DADS will continue its annual survey of the people who participate in its home and community-based services. The Quality Assurance and Improvement (QAI) unit shares the results of the survey are reviewed by TxHmL program staff for their assistance in evaluating improved strategies. The focus areas identified in the NCI survey include the following:

State:	TEXAS #0403
Effective Date	March 1, 2007

Consumer Outcomes. These indicators concern how well the public system aids adults with developmental disabilities to work, participate in their communities, have friends and sustain relationships, and exercise choice and self-determination. Other indicators in this domain probe how satisfied individuals are with services and supports.

System Performance. The system performance indicators address the following topics: (a) service coordination; (b) family and individual participation in provider-level decisions; (c) the utilization of and outlays for various types of services and supports; (d) cultural competency; and (e) access to services.

Health and Welfare. These indicators concern the following topics: (a) safety and personal security; (b) health and wellness; and (c) protection of and respect for individual rights.

Family Indicators. The family indicators concern how well the public system assists children and adults with developmental disabilities and their families, to exercise choice and control in their decision-making, participate in their communities, and maintain family relationships. Additional indicators probe how satisfied families are with services and supports they receive, and how supports have affected their lives.

QMP Element H4: **Compilation and Communication of Quality Management Information**

DADS is developing a Quality Assurance and Improvement Data Mart that will compile data currently collected in multiple automated systems. Consultants have designed a Data Mart that will produce standardized reports, as well as provide capability for ad hoc reporting. The areas covered by the reports will include participant demographics, service utilization, enrollments, levels of care, service plans, consumer-directed options, critical incidents, abuse, neglect, and exploitation, provider compliance and oversight, transfers, discharges, complaints, and recoupments. The system will have the capability to provide management reports at the participant level.

At least quarterly, DADS will compile a report regarding the quality assurance activities of the TxHmL Program and provide it to appropriate program staff for review and necessary action to meet the program goals and implementation of this QMP. Additionally, DADS Regulatory Services compiles a quarterly report of on-site program provider reviews, which is used to identify trends in provider performance and also serve as a basis for additional provider training.

On an annual basis, a report will be produced that will be based on discovery findings and include key information relevant to each assurance and information about participation in and the cost of the waiver based on the CMS-372 reports. The report will provide internal and external stakeholders with information on quality indicators, including status of remediation and improvement activities. The QAI unit will be responsible for routinely updating the QMP based on feedback from the VQC and other stakeholders.

QMP Element H5: **Periodic Evaluation and Revisions of the QMP**

It is anticipated that the results of this QMP will precipitate the need for on-going changes in policy, priorities, and activities. If QMP revisions are necessary they will be communicated through the CMS-372 report.

State:	TEXAS #0403
Effective Date	March 1, 2007

Conclusion

The QMP matrix that follows outlines the quality outcomes, discovery processes/activities, entity (ies) responsible for each, and the frequency of measurement. Data that is gathered through each of the discovery activities is used by responsible entities and the VQC to identify and recommend systematic remediation and improvement. An annual report, which encompasses all aggregate data collected, will be published and available to all stakeholders, including participants, families, providers of long term services and supports, the legislature, and the general public. Findings will also be incorporated into the CMS-372 report.

It is anticipated that this approach to quality management may precipitate the need for on-going changes in policy, priorities, and activities. The intent of quality management, however, will remain constant: to maintain accountability of public resources, ensure health and welfare, and support individual choice and control.

Quality Focus Area 1 – Level of Care and Participant Access

Desired Outcome: Individuals have access to home and community-based services and supports in their community.

Following the acceptance of an offer of TxHmL Program services by an individual or his/her legally authorized representative (LAR) or family, a local Mental Retardation Authority (MRA) collects documentation of the individual’s eligibility for an ICF/MR Level of Care I and completes the MR/RC Assessment form. The MRA must complete and submit the form electronically to DADS through the CARE System. DADS staff approves or deny the level of care submitted. The CARE System prohibits the completion of an individual’s enrollment without an approved level of care. The system also prohibits the renewal of an individual’s service plan if the individual’s level of care is not current.

Responsible Entity	Focus Area	Quality Domain or Assurance	Quality Indicator	Discovery Method and Frequency of Measurement
DADS-A & I	Assurance 1.1	An evaluation of level of care (LOC) is provided to all applicants for whom there is a reasonable indication that services may be needed in the future.	Percent of initial LOCs reviewed by DADS.	CARE system ongoing
DADS-A & I	Assurance 1.2	Enrolled participants are reevaluated at least annually or as specified in its approved waiver.	DADS reviews 100% of LOCs .	CARE system Ongoing
DADS-A & I	Assurance 1.3	The process and instruments described in the approved waiver are applied to determine LOC.	Percent of time the MR/RC Assessment Form, as prescribed in Appendix D, is used to determine LOC. Percent of time persons performing level of care determinations meet the minimum qualifications specified in Appendix B-6-c.	CARE system Ongoing Supervisory Personnel Records

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix H: Quality Management Strategy
 HCBS Waiver Application Version 3.3 – October 2005

DADS-A & I	Assurance 1.4	The state monitors level of care decisions and takes action to address inappropriate level of care determinations.	Percent of LOC determinations found to be incorrect, when challenged by, or on behalf of, the applicant.	Secondary review by supervisory staff ongoing
DADS-QAI	Information and Referral	Participants and families can readily obtain information concerning the availability of services, how to apply.	Percent of participants indicating satisfaction with information provided regarding availability of services and how to apply.	NCI Survey annually
DADS-QAI	User Friendly Process	Intake and eligibility determination processes are understandable and user friendly.	Percent of participants who felt the determination process was understandable and user friendly.	NCI Survey annually (under development)
DADS-QAI	Prompt Initiation	Services are initiated promptly when the applicant is determined eligible and selects services.	Percent of service plans that are initiated within one month of plan authorization.	QAI Data Mart quarterly (under development)

Quality Focus Area 2 –Service Plan and Participant-Centered Service Planning

Desired Outcome: Services and supports are planned and effectively implemented in accordance with each participant’s unique needs, expressed preferences and decisions concerning his/her life in the community.

Service coordinators employed by the MRA facilitate individual service planning. Service plans are developed using a person-directed planning process. The service coordinator convenes a service planning team that must include the individual and the individual’s legally authorized representative (LAR) and, at the invitation of the individual or LAR, other individuals important in developing the service plan such as providers of waiver or non-waiver services and family or friends. The Service Coordinator is responsible for assuring the plan is reviewed and revised at least annually and whenever indicated by changes in the individual’s service needs.

Responsible Entity	Focus Area	Quality Domain or Assurance	Quality Indicator	Discovery Method and Frequency of Measurement
DADS-A & I	Assurance 2.1		Percent of participant records evidencing that the Service Coordinator initiates, coordinates, and facilitates the person-directed planning process to meet the desires and needs as identified by the individual and LAR.	On-site MRA Review annually

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix H: Quality Management Strategy
 HCBS Waiver Application Version 3.3 – October 2005

DADS-RS	Assurance 2.1		Percent of providers presenting evidence that an individual, individual's family or LAR participated in the development of support methodologies to address outcomes identified through the person-directed planning process	On-site Program Provider Review annually
DADS-A & I	Assurance 2.2	The State monitors service plan development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the development of service plans.	Percent of participants whose service plan evidences development of the service plan in accordance with State policy and procedure.	On-site MRA Reviews annually
DADS-QAI	Assurance 2.2	See previous	Percent of people reporting that service coordinators asked about their preferences.	NCI Survey annually
DADS-A & I	Assurance 2.3	Service plans are updated/revised when warranted by changes in the waiver participant's needs.	Percent of participant records evidencing updated/revised service plan when individual needs warrant changes.	On-site MRA Reviews annually
DADS-RS	Assurance 2.4	Services are specified by type, amount, duration, scope and frequency and are delivered in accordance with the service plan.	Percent of service plans that provide all program components authorized in an individual's service plan.	On-site Program Provider Reviews annually
DADS-QAI	Assurance 2.4	See previous	Percent of people reporting that "needed" services were available	NCI Survey annually
DADS-A & I	Assurance 2.5	Participants are afforded choice: 1) between waiver services and institutional care and 2) between/among waiver services and providers.	Percent of participants or LARs that were given choice between waiver services and institutional care.	On-site MRA Reviews annually

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix H: Quality Management Strategy
 HCBS Waiver Application Version 3.3 – October 2005

DADS-RS	Assurance 2.5	See previous	Percent of providers who employ or contract with a service provider of the individual's or LAR's choice if that service provider is qualified.	On-site Program Provider Reviews annually
DADS-RS	Assurance 2.5	See previous	Percent of providers who inform the individual or LAR of provider's obligation to assist and cooperate with the individual's or Lars request to transfer to another TxHmL Program provider.	On-site Program Provider Reviews annually
DADS-A & I	Participant Direction	Participants have the authority and are supported to direct and manage their own services to the extent they wish.	Percent of participants who are offered the ability to manage their own services. Percent of participants who choose to manage their own services.	On-site MRA Reviews annually CARE System ongoing
DADS-QI	Ongoing Monitoring	Regular, systematic and objective methods – including obtaining the participant's feedback – are used to monitor the participant's well-being, health status, and effectiveness of the service in enabling the individual to achieve his or her personal goals.	Percent of consumers surveyed who report satisfaction with their services and supports in terms of addressing health and well being, and enabling the individual to achieve his or her personal goals.	NCI Survey annually

Quality Focus Area 3 - Qualified Providers - Capacity and Capabilities

Desired Outcome: There are sufficient service providers and they possess and demonstrate the capability to effectively serve participants

During on-site reviews of HCS Program providers, DADS staff sample personnel records to verify that all minimum provider qualifications are met and required training has been accomplished.

Responsible Entity	Focus Area	Quality Domain or Assurance	Quality Indicator	Discovery Method and Frequency of Measurement
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State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix H: Quality Management Strategy

HCBS Waiver Application Version 3.3 – October 2005

DADS-RS	Assurance 3.1	The State verifies, on a periodic basis, that providers meet required licensing and/or certification standards and adhere to other state standards.	Percent of program providers and CDSAs that are qualified by licensing, certification, or state regulations.	On-site Program Provider Reviews annually On-site CDSA Reviews biannually
DADS-RS	Assurance 3.2	The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.	Percent of program providers and CDSAs who have evidence that non-licensed providers of waiver services meet minimum background and training qualifications.	On-site Program Provider Reviews annually On-site CDSA Reviews biannually
DADS-RS	Assurance 3.3	The State identifies and rectifies situations where providers do not meet requirements.	Percent of program provider and CDSA reviews resulting in required corrective action to address non-compliance with requirements related to provider qualifications.	On-site Program Provider Reviews annually On-site CDSA Reviews biannually
DADS	Assurance 3.4	The state implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved program requirements.	Percent of on-site reviews that include review of evidence that service providers are qualified and trained as required by state rules and the waiver. Percent of on-site reviews of MRAs that include review of evidence that service providers are qualified and trained as required by state rules.	On-site Program Provider Reviews annually On-site CDSA Reviews Biannually On-site MRA Reviews Annually

State:	TEXAS #0403
Effective Date	March 1, 2007

Quality Focus Area 4 - Health and Welfare - Participant Safeguards

Desired Outcome: Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.

The Texas Department of Family and Protective Services (DFPS) is statutorily responsible for investigating allegations of abuse, neglect, or exploitation of individuals enrolled in the HCS Program. DFPS forwards to DADS a report of each of its investigations along with its determination that the allegation was confirmed or not confirmed or that results of the investigation were inconclusive. In accordance with state law, DADS maintains an Employee Misconduct Registry that includes the names of persons DADS or DFPS has confirmed to have abused, neglected, or exploited an individual receiving services in a licensed ICF/MR or through the TxHmL Program or the Home and Community-based Services Program (HCBSW #0110). In addition, in accordance with federal law, DADS maintains a Nurse Aide Registry that lists certified nurse aides. The Nurse Aide Registry indicates if an aide has been confirmed to have abused, neglected, or exploited a resident of a licensed nursing facility. Program providers and mental retardation 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 program providers and MRAs from employing a person whose criminal background indicates the person has been convicted of certain felonies. Program providers and MRAs are required to complete pre-employment criminal background checks for each non-licensed applicant that will provide services to an individual enrolled in the TxHmL Program.

Responsible Entity	Focus Area	Quality Domain or Assurance	Quality Indicator	Discovery Method and Frequency of Measurement
DADS-RS	Assurance 4.1	The state, on an ongoing basis, identifies and addresses and seeks to prevent instances of abuse, neglect and exploitation.	Percent of program providers demonstrating that personnel are trained and knowledgeable of acts constituting ANE, the requirements to report allegations of ANE, and methods to prevent ANE.	On-site Program Provider Reviews annually
DADS-RS	Assurance 4.1	See previous	Percent of program providers that comply with the requirement to not employ service providers ineligible due to information contained within criminal history checks, the nurse-aide registry or the employee misconduct registry.	On-site Program Provider Reviews annually On-site CDSA Reviews biannually

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix H: Quality Management Strategy
 HCBS Waiver Application Version 3.3 – October 2005

Responsible Entity	Focus Area	Quality Domain or Assurance	Quality Indicator	Discovery Method and Frequency of Measurement
DADS-RS	Assurance 4.1	The state, on an ongoing basis, identifies and addresses and seeks to prevent instances of abuse, neglect and exploitation.	Percent of program providers demonstrating that personnel are trained and knowledgeable of acts constituting ANE, the requirements to report allegations of ANE, and methods to prevent ANE.	On-site Program Provider Reviews annually
DADS-RS	Assurance 4.1	See previous	Percent of program providers that inform all individuals and individuals' families or LARs, instruct staff, and follow requirements in regard to ANE.	On-site Program Provider Reviews annually On-site CDSA Reviews biannually
DADS-RS	Assurance 4.1	See previous	Percent of providers that, upon confirmation of ANE by DFPS, take appropriate action to prevent recurrence of ANE.	On-site Program Provider Reviews annually
DADS-RS	Assurance 4.1	See previous	Staff at DADS review all reports of findings of ANE investigations and, if corrective action on the part of a TxHmL Program provider is warranted, DADS' staff conduct follow up.	Allegations of ANE Review ongoing
DADS-RS	Assurance 4.1	See previous	Percent of program providers reporting critical incidents monthly.	CARE System: Critical Incident Reporting subsystem monthly

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix H: Quality Management Strategy
 HCBS Waiver Application Version 3.3 – October 2005

Responsible Entity	Focus Area	Quality Domain or Assurance	Quality Indicator	Discovery Method and Frequency of Measurement
DADS-RS	Assurance 4.1	The state, on an ongoing basis, identifies and addresses and seeks to prevent instances of abuse, neglect and exploitation.	Percent of program providers demonstrating that personnel are trained and knowledgeable of acts constituting ANE, the requirements to report allegations of ANE, and methods to prevent ANE.	On-site Program Provider Reviews annually
DADS-RS	Assurance 4.1	See previous	Percent of participant records reviewed evidencing the participant or LAR was informed orally and in writing of the process for filing complaints	On-site Program Provider Reviews annually
DADS-CRSP	Assurance 4.1	See previous	Percent of complaints addressed by DADS	Consumer Rights and Services complaint data base ongoing
DADS-RS	Restrictive Interventions	Restrictive interventions - including chemical and physical restraints - are only used as a last resort and subject to rigorous oversight.	Percent of program providers that comply with safeguards related to the use of restrictive behavioral interventions.	On-site program provider review. annually

Quality Focus Area 5 - Administrative and Fiscal System Performance

Desired Outcome: The system supports participants efficiently and effectively and constantly strives to improve quality.

In accordance with 42 CFR §431.10 (e), the Texas Health and Human Services Commission is the single state Medicaid agency and retains administrative authority over the waiver program. The initial waiver, subsequent amendments, CMS 372 reports and all state rules for waiver program operations are subject to the review and approval/disapproval of HHSC. **HHSC Medicaid LTC staff is scheduling and conducting on-site visits to provider agencies and will be monitoring DADS' provider reviews. Additionally, HHSC Medicaid LTC staff is actively involved in program design changes such as the implementation of consumer direction options and in the development of quality assurance activities. HHSC leads the state's Consumer Direction Task Force and monitors DADS implementation of consumer direction activities on an ongoing basis through quarterly meetings and annual reports. HHSC and DADS staff hold regular status and update meetings directed at evaluating current quality systems and identifying and prioritizing enhancements. These meetings have**

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix H: Quality Management Strategy
 HCBS Waiver Application Version 3.3 – October 2005

resulted in plans to: enhance data reporting to the Medicaid agency, base-line current activities using the CMS Quality framework matrix,; initiate joint on-site reviews of program providers, and evaluate the development of a quality management strategy that spans more than one waiver and potentially other types of long-term care services.

Responsible Entity	Focus Area	Quality Domain or Assurance	Quality Indicator	Discovery Method and Frequency of Measurement
HHSC	Assurance 5.1	The Medicaid agency or operating agency conducts routine, ongoing oversight of the waiver program.	The operating agreement identifying policy-setting and oversight responsibilities is on file.	Review by State Medicaid Agency Review by State Medicaid Agency
HHSC	Assurance 5.1	See previous	The operating agreement is reviewed for updates.	Annual Review by State Medicaid Agency
HHSC	Assurance 5.1	See previous	The operating agreement is current.	Review by State Medicaid Agency
HHSC	Assurance 5.1	See previous	The need to update operating agreements is identified.	Review by State Medicaid Agency
HHSC	Assurance 5.1	See previous	The operating agreement has been updated.	The operating agreement is under review by State Medicaid Agency legal staff. Elements of the new waiver process as well as name changes of the agencies under recent state law are being considered for inclusion in the update.
HHSC	Assurance 5.1	See previous	HHSC monitors implementation of the agreement to ensure the operating agency executes provisions.	Review of actions taken under the State Medicaid Agency's administrative authority.
HHSC	Assurance 5.1	See previous	The operating agency reports the results of its monitoring activities to the State Medicaid Agency.	Review of reports by the State Medicaid Agency.
HHSC	Assurance 5.1	See previous	The operating agency submits the results of its monitoring to	Review of the 372s submitted

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix H: Quality Management Strategy
 HCBS Waiver Application Version 3.3 – October 2005

Responsible Entity	Focus Area	Quality Domain or Assurance	Quality Indicator	Discovery Method and Frequency of Measurement
HHSC	Assurance 5.1	The Medicaid agency or operating agency conducts routine, ongoing oversight of the waiver program.	The operating agreement identifying policy-setting and oversight responsibilities is on file.	Review by State Medicaid Agency Review by State Medicaid Agency
HHSC	Assurance 5.1	See previous	The operating agreement is reviewed for updates.	Annual Review by State Medicaid Agency
HHSC	Assurance 5.1	See previous	The operating agreement is current.	Review by State Medicaid Agency
HHSC	Assurance 5.1	See previous	The need to update operating agreements is identified.	Review by State Medicaid Agency
HHSC	Assurance 5.1	See previous	The operating agreement has been updated.	The operating agreement is under review by State Medicaid Agency legal staff. Elements of the new waiver process as well as name changes of the agencies under recent state law are being considered for inclusion in the update.
HHSC	Assurance 5.1	See previous	HHSC monitors implementation of the agreement to ensure the operating agency executes provisions.	Review of actions taken under the State Medicaid Agency's administrative authority.
			the State Medicaid Agency annually via the CMS 372 report.	
DADS	Administration	DADS executes Medicaid Provider Agreements on behalf of HHSC, the Texas Single State Medicaid Agency	Medicaid Provider Agreements specify that DADS executes the agreement on behalf of HHSC, the Texas Single State Medicaid Agency.	Amendments specifying that DADS executes the agreement on behalf of HHSC, the Texas Single State Medicaid Agency are executed no later than July 30, 2007.

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix H: Quality Management Strategy
 HCBS Waiver Application Version 3.3 – October 2005

Financial Accountability. Program providers enter billing claims into the CARE System, which assigns the correct reimbursement rate associated with the billing code entered by a program provider. The CARE System automatically rejects any claim that is entered with an unauthorized billing code or for a service not included in an individual’s authorized service plan.

Responsible Entity	Focus Area	Quality Domain or Assurance	Quality Indicator	Discovery Method and Frequency of Measurement
DADS-PS	Assurance 5.2	Consumer claims are coded and paid according to the waiver reimbursement methodology.	Percent of correctly coded claims reimbursed according to reimbursement methodology.	CARE System Ongoing
DADS-PS	Assurance 5.3	Codes used to bill participant claims are appropriate for the service provided.	Percent of dollars reimbursed for services provided to a participant that are correctly coded.	On-site Billing and Payment Reviews biannually Desk Reviews of requests for adaptive aids, minor home modifications and dental services ongoing
DADS QAI	System Performance Appraisal	The service system promotes the effective and efficient provision of services and supports by engaging in a systematic data collection and analysis of program performance and impact.	Review process planned but not implemented to review the following: <ul style="list-style-type: none"> • Per Capita costs. • Mortality rate. • Review of service plan and actual service utilization. • Billing Reviews. • Experience Surveys 	QAI Data Mart quarterly NCI Survey annually
DADS QAI	Quality Improvement	There is a systemic approach to the continuous improvement of quality in the provision of services.	Per Capita costs. Mortality rate. Percent of accurate prior authorization of services. Percent of incorrect billing edits. Review of service plan and actual service utilization. Billing Reviews	QAI Data Mart routinely Measuring Quality Experience Survey annual.

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix H: Quality Management Strategy
 HCBS Waiver Application Version 3.3 – October 2005

Responsible Entity	Focus Area	Quality Domain or Assurance	Quality Indicator	Discovery Method and Frequency of Measurement
			Experience Surveys	
DADS-QAI	Participant and Stakeholder Involvement	Participants and other stakeholders have an active role in program design, performance appraisal, and quality improvement activities.	Number of participant and/or stakeholder meetings to discuss design, performance, appraisal and quality improvement activities.	DADS Virtual Quality Consortium (in development)
DADS-QAI	Cultural Competency	The service system effectively supports participants of diverse cultural and ethnic backgrounds.	Services are available in all parts of Service Area regardless of ethnic background and with respect and dignity of culture.	Children/Family Experience surveys available in English and Spanish. Face-to-Face survey contract interviewers are required to use interpreters if applicable.
DADS-QAI	Financial Integrity	Financial accountability is assured and payments are made promptly in accordance with program requirements.	Percent of payments made in error. Percent of payments made outside the required timeframe.	CARE System ongoing

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix I: Financial Accountability

APPENDIX 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 Texas Home Living program providers and CDSA's are complying with program requirements. DADS conducts fiscal monitoring of TxHmL Program providers on-site at least every four years and typically reviews a three month sample of the provider's records, but may lengthen that sample period, if deemed necessary. Fiscal monitoring of CDSAs is conducted every two years. The methods used in the monitoring process include:

- Review of the provider agency'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 CDSA were appropriate and for services provided in compliance with the provider's contract with DADS and with the rules and regulations for those services;
- Individual's service plans and records; and
Comparison of service delivery and other supporting documentation with individual service plans.

As initial results warrant, DADS may broaden the scope of the review to include inspection of the service settings, observation of service provision, examination of personnel qualifications, and interviews with participants, or the participants' families, or service providers.

DADS may perform desk and on-site compliance reviews associated with claims the provider agency submits under a contract. DADS recovers improper payments, without extrapolation, when DADS verifies that the provider agency has been overpaid because of improper billing or accounting practices or failure to comply with the contract terms.

The provider agency must provide the detailed information DADS requests that supports the claims information the provider agency reported. If the provider agency fails to provide the requested information, DADS may take adverse action against the provider agency's contract.

DADS may withhold the provider agency's payments and apply them to the billing and payment review exception for any payments the provider agency 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 Office of the Inspector General is responsible for performing audits of contracts between DADS and providers.

State:	TEXAS #0403
Effective Date	March 1, 2007

APPENDIX I-2: Rates, Billing and Claims

- 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).

The Texas Health and Human Services Commission (HHSC), the single state Medicaid agency, determines payment rates every two years. Payment rates are determined for each service and the rates for services are prospective and uniform statewide.

Rates are determined based on other Medicaid waiver programs providing similar services.

All program providers are required to submit annual cost reports. Providers are responsible for eliminating all unallowable expenses from the cost report prior to submission of the cost report. The annual cost report contains information on direct service costs, including direct service wages, benefits, contract services and staffing information.

In the Consumer-Directed Service (CDS) option, the sum of the payment rate for the contracted CDS agency (the provider of financial management services) and the payment rate available for the consumer/employer participating in the CDS option, must not exceed the payment rate made to a TxHmL program provider. **The State will reimburse a CDS agency a one-time fee to complete necessary “start-up” tasks when a participant first elects the CDS option. These tasks include activities such as conducting orientation with the participant employer and, if applicable, the Designated Representative; registering the employer with the Internal Revenue Service and state agencies such as Texas Workforce Commission; developing a consumer-directed service budget for each service to be self-directed; establishing compensation plans for a specific employee/service provider; providing information on qualified service providers; and assisting in completing background checks. Following a participant’s initial enrollment into the CDS Option, a CDSA will be reimbursed a monthly fee when it submits a reimbursement claim on behalf of the participant employer during a month. The reimbursement rate for the one-time start-up fee and the monthly fee are determined by modeling the estimated cost to provide financial management services.**

HHSC holds a public hearing on proposed reimbursement rates before HHSC 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 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, materials pertinent to the proposed statewide uniform reimbursements are made available to the public.

- 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:

TxHmL Program providers and CDSAs submit billing claims directly to DADS.

TxHmL Program providers and CDSAs enter individual service usage information (billing claims) into the DADS electronic billing system. TxHmL provider agencies and CDSAs submit appropriate receipts for adaptive aids, minor home modifications, and dental treatment that are authorized for payment by DADS staff. Following authorization, the TxHmL Program providers

State:	TEXAS #0403
Effective Date	March 1, 2007

and CDSAs submit electronic claims for the adaptive aids, minor home modifications, or dental treatment.

c. Certifying Public Expenditures (*select one*):

<input type="radio"/>	Yes. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (<i>check each that applies</i>):
<input type="checkbox"/>	Certified Public Expenditures (CPE) of State Public Agencies. Specify: (a) the public 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). (<i>Indicate source of revenue for CPEs in Item I-4-a.</i>)
<input type="checkbox"/>	Certified Public Expenditures (CPE) of Non-State Public Agencies. Specify: (a) the non-State public 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). (<i>Indicate source of revenue for CPEs in Item I-4-b.</i>)
<input checked="" type="checkbox"/>	No. Public agencies do not certify expenditures for waiver services.

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 individual’s approved service plan; and, (c) the services were provided:

TxHmL Program providers and CDSAs may enter electronic billing claims weekly. A claim includes the total units of each service component delivered to an individual, the date of delivery, and the amount due the program provider. DADS electronic billing system verifies the following before a billing claims is approved:

- The individual meets level of care and financial eligibility requirements on the date of service;
- The service components billed are included on the individual's current, approved service plan;
- The amount of units and unit costs do not exceed the most current, approved service plan; and
- The billing claim is complete, accurate, and is received by DADS within 95 calendar days from the end of the month of service.

TxHmL Program providers and CDSAs submit appropriate receipts for adaptive aids, minor home modifications, and dental treatment that are authorized for payment by DADS staff. Following authorization, the provider agencies and CDSAs submit electronic claims for the adaptive aids, minor home modifications or dental treatment.

DADS uses a fiscal monitoring process to ensure that reimbursement to TxHmL Program providers and CDSAs are for services actually provided in compliance with program requirements. The methods used in the fiscal monitoring process and outcomes of the process are described in Appendix I-1.

State:	TEXAS #0403
Effective Date	March 1, 2007

- 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 §74.53.

State:	TEXAS #0403
Effective Date	March 1, 2007

APPENDIX I-3: Payment

a. Method of payments — MMIS (select one):

<input checked="" type="checkbox"/>	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
<input type="checkbox"/>	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.
<input checked="" type="checkbox"/>	<p>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:</p> <p>Once a week, a process is run to compare the received claims to the criteria for approval of claims to produce a list of adjudicated/approved claims to be processed for payment. Rate tables support the computation of the amount to pay and approved-to-pay claims are exported weekly to the TxHmL Provider Payment System. The TxHmL Provider Payment System computes the federal and general revenue funding split for each approved-to-pay claim, determines the accounting coding block and builds interface transactions to the agency’s accounts payable system, the Health and Human Services Accounting System (HHSAS). HHSAS prepares a warrant request that is sent to the Comptroller of Public Accounts who, in turn, produces a warrant that is sent to the TxHmL provider or CDSA. The data used for the claims and expenditures on the CMS 64 is this adjudicated claim information contained in HHSAS.</p> <p>DADS, the local MRA providing service coordination for the individual, the TxHmL Program provider, and the CDSA and individual employer in the CDS option maintain supporting documentation in connection with an audit trail.</p> <p>DADS retains copies of Program Provider Agreements between DADS and each certified program provider and CDSA along with documentation of each program provider’s and CDSA’s compliance with state standards for participation.</p> <p>DADS maintains the following documentation related to each individual:</p> <ul style="list-style-type: none"> ▪ Approved service plans; ▪ Documentation of the individual's financial eligibility and level of care eligibility; ▪ A record for each individual that documents the content of service plans and details of all services approved or rejected for payment including the number of service units delivered, the date of service delivery, the amount claimed for reimbursement, copies of receipts for adaptive aids, minor home modifications and dental services, and the amount approved for reimbursement; and ▪ Records of discharges of individuals from waiver services.

State:	TEXAS #0403
Effective Date	March 1, 2007

	<p>Local MRAs maintain separate service information for each waiver program applicant/participant receiving service coordination from the authority. The MRA maintains, at minimum, the following information:</p> <ul style="list-style-type: none"> • A record of the individual's Medicaid eligibility; • Documentation of the individual's choice of waiver services as an alternative to ICF-MR services; • Documentation of service coordination activities; • Initial level-of-care determination and all re-evaluations of level-of-care; • Results of individual assessments, evaluations, and accompanying recommendations that identify specific needs to be addressed by the service components included on the individual's service plan; • Service plans and revisions to plans for each individual; • Person-directed plan for each individual; • Verification by DADS of the date of individual's eligibility for enrollment and of program provider eligibility for payment and, when applicable, records of individual's discharge from waiver services; • When applicable, documentation verifying the recipient's eligibility for employment assistance or supported employment. <p>Program Providers, and CDSAs and individual employers in the CDS option, must maintain separate service information for each individual receiving services from the provider. At a minimum, service documentation information includes the following:</p> <ul style="list-style-type: none"> • Results of individual assessments, evaluations, and accompanying recommendations that identify specific needs to be addressed by the service components included on the individual's service plan; • Service plans and revisions to plans for each individual; • Person-directed Plan for each individual; • Copies of billings and vouchers submitted for reimbursement; • Service delivery logs indicating date and type of service provided and name of service provider; • Narrative documentation of outcomes of each service delivery event; • Verification by DADS of the date of the individual's eligibility for enrollment and of provider eligibility for payment and, when applicable, records of individual's discharge from waiver services; • When applicable, documentation verifying the individual's eligibility for employment assistance or supported employment; • When applicable, receipts for the provision of adaptive aids, minor home modifications, and dental treatment and documentation that the provision of dental treatment, adaptive aids or minor home modifications is authorized by the recipient's service planning team; and • Evidence that all service providers meet the minimum provider qualifications at the time services were delivered.
○	<p>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:</p>

State:	TEXAS #0403
Effective Date	March 1, 2007

b. Direct payment. Payments for waiver services are made utilizing one or more of the following arrangements (*check each that applies*):

<input checked="" type="checkbox"/>	The Medicaid agency makes payments directly to providers of waiver services.
<input type="checkbox"/>	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
<input checked="" type="checkbox"/>	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: HHSC has delegated the functions of limited fiscal agent to DADS. HHSC oversees performance of these functions by assuring DADS has included appropriate edits in the automated billing system.
<input type="checkbox"/>	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.

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:*

<input checked="" type="radio"/>	No. The State does not make supplemental or enhanced payments for waiver services.
<input type="radio"/>	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 and (b) the types of providers to which such payments are made. 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.

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

<input checked="" type="checkbox"/>	Yes. Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. <i>Complete item I-3-e.</i> DADS contracts with local community centers, established in accordance with Chapter 534 of the Texas Health and Safety Code, and with a local Council of Government (COG), established in accordance with Chapter 391 of the Texas Local Government Code, which have all been designated by DADS as Mental Retardation Authorities (MRAs). MRAs contract as TxHmL program providers, and, therefore, must provide all TxHmL services and receive payment for services provided. MRAs may also contract to provide financial management services under the CDS option.
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State:	TEXAS #0403
Effective Date	March 1, 2007

<input type="radio"/>	No. Public providers do not receive payment for waiver services. <i>Do not complete Item I-3-e.</i>
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e. Amount of Payment to Public Providers. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

<input checked="" type="radio"/>	The amount paid to public providers is the same as the amount paid to private providers of the same service.
<input type="radio"/>	The amount paid to public 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.
<input type="radio"/>	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public 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:

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:*

<input checked="" type="radio"/>	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
<input type="radio"/>	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
<input type="radio"/>	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.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

<input type="radio"/>	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.
<input checked="" type="radio"/>	No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

State:	TEXAS #0403
Effective Date	March 1, 2007

<input type="radio"/>	Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDs and how these entities qualify for designation as an OHCDs; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDs; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDs arrangement is employed, including the selection of providers not affiliated with the OHCDs; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDs meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDs contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDs arrangement is used:
<input checked="" type="radio"/>	No. The State does not employ Organized Health Care Delivery System (OHCDs) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. Select one:

<input type="radio"/>	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may <i>voluntarily</i> elect to receive <i>waiver</i> 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.
<input type="radio"/>	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain <i>waiver</i> 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.
<input checked="" type="radio"/>	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

State:	TEXAS #0403
Effective Date	March 1, 2007

APPENDIX I-4: Non-Federal Matching Funds

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. *Check each that applies:*

<input type="checkbox"/>	Appropriation of State Tax Revenues to the State Medicaid agency
<input checked="" type="checkbox"/>	<p>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 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 public agencies as CPEs, as indicated in Item I-2-c:</p> <p>The non-federal share of TxHmL funds are appropriated by the Texas State Legislature to the Texas Department of Aging and Disability Services (DADS), the department designated by the Texas Health and Human Services Commission, the single state Medicaid Agency, as the Medicaid operating agency for the TxHmL program. There are no IGT's or CPE's. The non-federal share is exclusively from state general revenue appropriations.</p> <ul style="list-style-type: none"> • There are no local sources of funds. • There are no certified public expenditures. • TxHmL non-federal share funds are appropriated to DADS as a specific line item for the provision of TxHmL services. • If another agency was designated to operate the TxHmL program, those funds would be removed from DADS and appropriated to that agency. <p>DADS TxHmL appropriations remain in the state comptrollers account designated for the TxHmL program. Once the Medicaid Agency has approved a claim via the Health and Human Services Accounting System (HHSAS), federal funds are drawn and combined with the state appropriation to make payments to the provider.</p>
<input type="checkbox"/>	<p>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 public agencies as CPEs, as indicated in Item I-2- c:</p>

b. Local 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. *Check each that applies:*

<input type="checkbox"/>	<p>Appropriation of Local Revenues. Specify: (a) the local 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 public agencies as CPEs, as specified in Item I-2- c:</p>
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State:	TEXAS #0403
Effective Date	March 1, 2007

<input type="checkbox"/>	Other non-State Level Source(s) of Funds. Specify: (a) the source of funds; (b) the 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 public agencies as CPEs, as specified in Item I-2- c:
<input checked="" type="checkbox"/>	Not Applicable. There are no non-State level sources of funds for the non-federal share.

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. *Check each that applies.*

<input type="checkbox"/>	Provider taxes or fees
<input type="checkbox"/>	Provider donations
<input type="checkbox"/>	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:
<input checked="" type="checkbox"/>	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

State:	TEXAS #0403
Effective Date	March 1, 2007

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

<input checked="" type="radio"/>	No services under this waiver are furnished in residential settings other than the private residence of the individual. <i>(Do not complete Item I-5-b).</i>
<input type="radio"/>	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. <i>(Complete Item I-5-b)</i>

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:

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State:	TEXAS #0403
Effective Date	March 1, 2007

APPENDIX 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:

<input type="radio"/>	<p>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. <i>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:</i></p>
<input checked="" type="radio"/>	<p>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.</p>

State:	TEXAS
Effective Date	March 1, 2007

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

- a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services as provided in 42 CFR §447.50. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

<input checked="" type="radio"/>	No. The State does not impose a co-payment or similar charge upon participants for waiver services. <i>(Do not complete the remaining items; proceed to Item I-7-b).</i>
<input type="radio"/>	Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services. <i>(Complete the remaining items)</i>

- i. Co-Pay Arrangement** Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies):*

<i>Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):</i>	
<input type="checkbox"/>	Nominal deductible
<input type="checkbox"/>	Coinsurance
<input type="checkbox"/>	Co-Payment
<input type="checkbox"/>	Other charge <i>(specify):</i>

- ii Participants Subject to Co-pay Charges for Waiver Services.** Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded. The groups of participants who are excluded must comply with 42 CFR §447.53.

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- iii. Amount of Co-Pay Charges for Waiver Services.** In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge. The amount of the charge must comply with the maximum amounts set forth in 42 CFR §447.54.

Waiver Service	Amount of Charge	Basis of the Charge

State:	TEXAS #0403
Effective Date	March 1, 2007

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant (*select one*):

<input checked="" type="radio"/>	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
<input type="radio"/>	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. In accordance with 42 CFR §447.53(e), the State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one*:

<input checked="" type="radio"/>	No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
<input type="radio"/>	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 as set forth in 42 CFR §447.52; (c) the groups of participants subject to cost-sharing and the groups who are excluded (groups of participants who are excluded must comply with 42 CFR §447.53); and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care (<i>specify</i>):							
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Column 7 less Column 4)
1	3,751.70	5,330.57	9,082.27	41,583.59	4,028.65	45,612.24	36,529.97
2	3,850.91	5,419.60	9,270.51	42,278.04	4,095.93	46,373.97	37,103.46
3	3,971.28	5,509.03	9,480.31	42,975.63	4,163.52	47,139.15	37,658.84
4	4,036.35	5,599.93	9,636.28	43,684.73	4,232.22	47,916.95	38,280.67
5	4,103.00	5,692.33	9,795.33	44,405.53	4,302.06	48,707.59	38,912.26

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix J-2 - Derivation of Estimates

- 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 Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		ICF/MR I	N/A
Year 1	2,762	2,762	
Year 2	3,074	3,074	
Year 3	3,401	3,401	
Year 4 (renewal only)	3,401	3,401	
Year 5 (renewal only)	3,401	3,401	

- 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-d.

The estimate of the average length of stay (ALOS) is based on the State’s experience during waiver year 3 in which attrition from this waiver occurred at a higher rate than the ALOS data reported in the annual report, CMS 372, for the waiver for waiver year 2 (2005-2006). The higher attrition rate has resulted from the State’s interest list reduction initiative, which began in September 2006. Many individuals enrolled in the TxHmL Program are registered on interest lists for one or more of the State’s other waiver programs and are accepting offers of enrollment into the State’s other waiver programs. Because the State expects the attrition rate experienced so far in waiver year 3 to continue, an average length of stay of 273 days is used as a basis in estimating waiver costs.

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The Factor D estimates are based on service utilization data reported in the CMS 372 report for the second year of this waiver (2005-2006) with the exception of Extended State Plan Service: Prescriptions, Financial Management, and Support Consultation. The estimates assume average unit cost based on current adopted rates. After year one, these rates are inflated forward to each subsequent renewal year using the Implicit Price Deflator (IPD).

Estimates for the Prescriptions are based on paid claims data for State Fiscal Year 2005. The estimates of the number of individuals using the CDS support services, Financial Management and Support Consultation, are based on the State’s experience in the CLASS Program (HCBSW #0221). The State projects that 15 percent of participants will elect the CDS Option during year one followed by 20 percent during year two, and 25 percent during years three-five.

State:	TEXAS #0403
Effective Date	March 1, 2007

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor D' estimates are based on actual costs of all other Medicaid services as reported in the CMS 372 report for the second year of this waiver (2005-2006) minus the costs for prescribed drugs above the three per month provided under the State Medicaid Plan. Beginning in year two, estimated D' costs are inflated by using both the IPD-Medical Care and IPD-Drugs cost inflators.

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor G estimates are based on the average cost of ICF/MR services as reported in the CMS 372 report for the second year of this waiver (2005-2006). Data used to prepare the 372 report were actual costs of ICF/MR services. This factor is estimated using the annual cost of ICF/MR services for individual who were living in their own or family home prior to enrollment in the ICF/MR Program. After year one, these rates are inflated forward to each subsequent renewal year using the IPD.

- iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor G' estimates are based on actual costs of all other Medicaid services as reported in the CMS 372 report for the second year of this waiver (2005-2006). Data used to prepare the 372 report were actual costs of Medicaid services other than ICF/MR services, provided to individuals receiving services in the ICF/MR Program who were living in their own or family home prior to enrollment in the ICF/MR Program. After year one, these rates are inflated forward to each subsequent renewal year using both the IPD-Medical Care and IPD-Drugs cost inflators.

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix J: Cost Neutrality Demonstration
 HCBS Waiver Application Version 3.3 – October 2005

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

<input checked="" type="radio"/>	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
<input type="radio"/>	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Community Support	Hourly	1,789	89	\$19.63	\$3,125,508.23
Day Habilitation	Daily	1,361	118	\$18.97	\$3,046,544.06
Employment Assistance	Hourly	179	23	\$24.42	\$100,537.14
Supported Employment	Hourly	235	27	\$24.42	\$154,944.90
Respite	Hourly	860	20	\$10.89	\$187,308.00
Respite	Daily	241	19	\$112.49	\$515,091.71
Nursing	Hourly	618	2	\$57.27	\$70,785.72
Behavioral Support	Hourly	150	5	\$68.91	\$51,682.50
Occupational Therapy	Hourly	42	2	\$69.00	\$5,796.00
Physical therapy	Hourly	57	5	\$69.00	\$19,665.00
Speech and Language Path.	Hourly	55	6	\$69.00	\$22,770.00
Audiology	Hourly	10	1	\$69.00	\$690.00
Dietary	Hourly	53	2	\$48.36	\$5,126.16
Dental	Tx	806	1	\$432.59	\$348,667.54
Adaptive Aids	Item	167	1	\$200.72	\$33,520.24
Minor home Modifications	Item	7	1	\$2,789.28	\$19,524.96
Financial Management: Monthly Fee	Monthly	414	12	\$160.00	\$794,880.00
Financial Management: Enrollment	CDS Enrollment	414	1	\$40.00	\$16,560.00
Support Consultation	Hourly	414	24	\$19.05	\$189,280.80
Extended State Plan: Prescriptions	Rx	1,585	10	\$104.31	\$1,653,313.50
GRAND TOTAL:					\$10,362,196.46
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					2,762
FACTOR D (Divide grand total by number of participants)					\$3,751.70
AVERAGE LENGTH OF STAY ON THE WAIVER					278

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix J: Cost Neutrality Demonstration
 HCBS Waiver Application Version 3.3 – October 2005

Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Community Support	Hourly	1,991	89	\$19.96	\$3,536,892.04
Day Habilitation	Daily	1,515	118	\$19.29	\$3,448,473.30
Employment Assistance	Hourly	199	23	\$24.83	\$113,646.91
Supported Employment	Hourly	261	27	\$24.83	\$174,977.01
Respite	Hourly	957	20	\$11.07	\$211,879.80
Respite	Daily	268	19	\$114.37	\$582,372.04
Nursing	Hourly	688	2	\$58.23	\$80,124.48
Behavioral Support	Hourly	167	5	\$70.06	\$58,500.10
Occupational Therapy	Hourly	47	2	\$70.15	\$6,594.10
Physical therapy	Hourly	64	5	\$70.15	\$22,448.00
Speech and Language Path.	Hourly	61	6	\$70.15	\$25,674.90
Audiology	Hourly	10	1	\$70.15	\$701.50
Dietary	Hourly	59	2	\$49.17	\$5,802.06
Dental	Tx	806	1	\$439.81	\$354,486.86
Adaptive Aids	Item	111	1	\$204.03	\$22,647.33
Minor home Modifications	Item	6	1	\$2,835.30	\$17,011.80
Financial Management: Monthly Fee	Monthly	615	12	\$162.67	\$1,200,504.60
Financial Management: Enrollment	CDS Enrollment	201	1	40.66	\$8,172.66
Support Consultation	Hourly	615	24	\$19.37	\$285,901.20
Extended State Plan: Prescriptions	Rx	1,585	10	\$106.03	\$1,680,575.50
GRAND TOTAL:					\$11,837,710.99
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					3,074
FACTOR D (Divide grand total by number of participants)					\$3,850.91
AVERAGE LENGTH OF STAY ON THE WAIVER					287

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix J: Cost Neutrality Demonstration
 HCBS Waiver Application Version 3.3 – October 2005

Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Community Support	Hourly	2,203	89	\$20.29	\$3,978,199.43
Day Habilitation	Daily	1,676	118	\$19.61	\$3,878,230.48
Employment Assistance	Hourly	220	23	\$25.24	\$127,714.40
Supported Employment	Hourly	289	27	\$25.24	\$196,947.72
Respite	Hourly	1,059	20	\$11.25	\$238,275.00
Respite	Daily	297	19	\$116.26	\$656,055.18
Nursing	Hourly	761	2	\$59.19	\$90,087.18
Behavioral Support	Hourly	184	5	\$71.22	\$65,522.40
Occupational Therapy	Hourly	52	2	\$71.31	\$7,416.24
Physical therapy	Hourly	70	5	\$71.31	\$24,958.50
Speech and Language Path.	Hourly	67	6	\$71.31	\$28,666.62
Audiology	Hourly	10	1	\$71.31	\$713.10
Dietary	Hourly	66	2	\$49.98	\$6,597.36
Dental	Tx	806	1	\$447.07	\$360,338.42
Adaptive Aids	Item	111	1	\$207.40	\$23,021.40
Minor home Modifications	Item	6	1	\$2,882.08	\$17,292.48
Financial Management: Monthly	Monthly	850	12	\$165.36	\$1,686,570.00
Financial Management: Enrollment	CDS Enrollment	235	1	\$41.33	\$9,712.55
Support Consultation	Hourly	850	24	\$19.69	\$401,676.00
Extended State Plan: Prescriptions	Rx	1,585	10	\$107.78	\$1,708,313.00
GRAND TOTAL:					\$13,506,315.32
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					3,401
FACTOR D (Divide grand total by number of participants)					\$3,971.28
AVERAGE LENGTH OF STAY ON THE WAIVER					293

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix J: Cost Neutrality Demonstration
 HCBS Waiver Application Version 3.3 – October 2005

Waiver Year: Year 4 (renewal only)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Community Support	Hourly	2,203	89	\$20.62	\$4,042,901.54
Day Habilitation	Daily	1,676	118	\$19.93	\$3,941,516.24
Employment Assistance	Hourly	220	23	\$25.66	\$129,839.60
Supported Employment	Hourly	289	27	\$25.66	\$200,224.98
Respite	Hourly	1,059	20	\$11.44	\$242,299.20
Respite	Daily	297	19	\$118.18	\$666,889.74
Nursing	Hourly	761	2	\$60.17	\$91,578.74
Behavioral Support	Hourly	184	5	\$72.40	\$66,608.00
Occupational Therapy	Hourly	52	2	\$72.49	\$7,538.96
Physical therapy	Hourly	70	5	\$72.49	\$25,371.50
Speech and Language Path.	Hourly	67	6	\$72.49	\$29,140.98
Audiology	Hourly	10	1	\$72.49	\$724.90
Dietary	Hourly	66	2	\$50.80	\$6,705.60
Dental	Tx	806	1	\$454.45	\$366,286.70
Adaptive Aids	Item	111	1	\$210.82	\$23,401.02
Minor home Modifications	Item	6	1	\$2,929.63	\$17,577.78
Financial Management: Monthly	Monthly	850	12	\$168.08	\$1,714,416.00
Financial Management: Enrollment	CDS Enrollment	235	1	42.01	\$9,872.35
Support Consultation	Hourly	850	24	\$19.05	\$408,204.00
Extended State Plan: Prescriptions	Rx	1,585	10	\$109.56	\$1,736,526.00
GRAND TOTAL:					\$13,727,631.75
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					3,401
FACTOR D (Divide grand total by number of participants)					\$4,036.35
AVERAGE LENGTH OF STAY ON THE WAIVER					309

State:	TEXAS #0403
Effective Date	March 1, 2007

Appendix J: Cost Neutrality Demonstration
 HCBS Waiver Application Version 3.3 – October 2005

Waiver Year: Year 5 (renewal only)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Community Support	Hourly	2,203	89	\$20.96	\$4,109,564.32
Day Habilitation	Daily	1,676	118	\$20.26	\$4,006,779.68
Employment Assistance	Hourly	220	23	\$26.08	\$131,964.80
Supported Employment	Hourly	289	27	\$26.08	\$203,502.24
Respite	Hourly	1,059	20	\$11.63	\$246,323.40
Respite	Daily	297	19	\$120.13	\$677,893.59
Nursing	Hourly	761	2	\$61.16	\$93,085.52
Behavioral Support	Hourly	184	5	\$73.59	\$67,702.80
Occupational Therapy	Hourly	52	2	\$73.69	\$7,663.76
Physical therapy	Hourly	70	5	\$73.69	\$25,791.50
Speech and Language Path.	Hourly	67	6	\$73.69	\$29,623.38
Audiology	Hourly	10	1	\$73.69	\$736.90
Dietary	Hourly	66	2	\$51.64	\$6,816.48
Dental	Tx	806	1	\$461.95	\$372,331.70
Adaptive Aids	Item	111	1	\$214.30	\$23,787.30
Minor home Modifications	Item	6	1	\$2,977.97	\$17,867.82
Financial Management: Monthly	Monthly	850	12	\$170.85	\$1,742,670.00
Financial Management: Enrollment	CDS Enrollment	235	1	42.71	10,034.50
Support Consultation	Hourly	850	24	\$20.34	\$414,936.00
Extended State Plan: Prescriptions	Rx	1,585	10	\$111.37	\$1,765,214.50
GRAND TOTAL:					\$13,954,298.17
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					3,401
FACTOR D (Divide grand total by number of participants)					\$4,103.00
AVERAGE LENGTH OF STAY ON THE WAIVER					309

State:	TEXAS #0403
Effective Date	March 1, 2007