

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
There are no major changes to the approved waiver being made in this renewal application.

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

1. Request Information (1 of 3)

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

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

- 3 years 5 years

Waiver Number:TX.0403.R02.00

Draft ID: TX.43.02.00

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

Regular Waiver

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

03/01/12

Approved Effective Date: 03/01/12

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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

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

Nursing Facility

Select applicable level of care

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

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

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

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

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

This waiver is limited to intermediate care facility level of care I.

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

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

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

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

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

§1915(b)(2) (central broker)

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

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

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

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

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

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

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods. The Texas Home Living Program (TxHmL), first authorized March 1, 2004, provides essential community-based services and supports to individuals with an intellectual and developmental disability 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 consumer directed services option and the traditional service delivery option. Individuals 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 39 local authorities. Service coordination for individuals enrolled in the TxHmL Program is funded through the State's Targeted Case Management Program. The local authority serving the geographic area in which the individual lives provides initial and ongoing service coordination in accordance with its Performance Contract with the Texas Department of Aging and Disability Services (DADS) and with DADS rules, which govern 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, assisting the individual in accessing non-waiver services, and continuously monitoring 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 Services 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 Title 1 of the Texas Administrative Code, 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, 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 HHSC/DADS Texas Medicaid provider agreements, conducting training and technical assistance concerning waiver requirements, and performing quality management functions.

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

- D. Participant-Centered Service Planning and Delivery.** **Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
 - No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*
- F. Participant Rights.** **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** **Appendix H** contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

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

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

- Geographic Limitation.** A waiver of statewide is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

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

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the

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

I. Public Input. Describe how the State secures public input into the development of the waiver:

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

DADS conducted a stakeholder webinar in January 2011 that allowed input regarding waiver operations and waiver services. Conducting a webinar has the potential of allowing up to 1,000 participants.

DADS has been involved in regular meetings with the Public Private Coalition which includes representative of the public and private sectors, including consumer advocates. At these meetings various issues were discussed to include such items as increasing enrollment due to refinancing.

DADS has been hosting regular meetings with representatives from local authorities, providers and advocates dealing with waivers for individuals with cognitive disabilities to revise billing guidelines, change required documentation of services to reduce administrative burden and other issues relevant to the TxHmL waiver.

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

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

For the waiver renewal, the Public Notice of Intent was published in the Texas Register on October 14, 2011. Tribal notification was mailed to the tribes on September 9, 2011, allowing a comment period. There were no comments received. Comment period expired on October 9, 2011.

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

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

7. Contact Person(s)

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

Johnson

First Name:

Betsy

Title:

Policy Analyst

Agency:

Texas Health and Human Services Commission

Address:

11209 Metric Blvd H-620

Address 2:

City:

Austin

State:

Texas

Zip:

78758

Phone:

(512) 491-1199

Ext:

TTY

Fax:

(512) 491-1953

E-mail:

betsy.johnson@hhsc.state.tx.us

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

Last Name:

Williamson

First Name:

Dana

Title:

Manager

Agency:

Texas Department of Aging and Disability Services

Address:

701 West 51st Street

Address 2:

P.O. Box 149030

City:

Austin

State:

Texas

Zip:

78714-9030

Phone:

(512) 438-3385

Ext:

TTY

Fax:

(512) 438-5768

E-mail:

dana.williamson@dads.state.tx.us

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:

Christine Longoria

State Medicaid Director or Designee

Submission Date:

Mar 13, 2012

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

submits the application.

Last Name:

Millwee

First Name:

Billy

Title:

State Medicaid Director

Agency:

Texas Health and Human Services Commission

Address:

11209 Metric Blvd.

Address 2:

Braker H-100

City:

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State:

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Zip:

78758

Phone:

(512) 491-1463

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(512) 491-1977

E-mail:

billy.millwee@hhsc.state.tx.us

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

not applicable

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the State Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

The Texas Department of Aging and Disability Services

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the

Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

In 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 is the designated operating agency for this waiver. The Long Term Services and Supports 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 HHSC or proposed amendments for waiver programs with final approval by HHSC. The Long Term Services and Supports Policy Unit is responsible for approving all waivers and the CMS-372 reports. In addition, the Long Term Services and Supports 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. Additionally, HHSC Medicaid Long Term Services and Supports Policy Unit 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 Workgroup and monitors DADS implementation of consumer direction activities on an ongoing basis through quarterly meetings and annual reports.

HHSC Medicaid Long Term Services and Supports Policy Unit 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, and develop 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 intellectual and developmental disability services. This is accomplished through performance contracts with local agencies called local authorities. As delegated by HHSC to DADS, local authorities contract with DADS to provide for the dissemination of information about intellectual and developmental disability services, including waiver services. Local authorities assist individuals enrolling into the TxHmL Program as well as other state intellectual and developmental disability 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.

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 monitoring staff.

In accordance with CMS quality framework guidelines, HHSC and DADS have 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.

Appendix A: Waiver Administration and Operation

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

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

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

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

Appendix A: Waiver Administration and Operation

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

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

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

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

DADS holds performance contracts with local community centers, established in accordance with Texas Health and Safety Code, Chapter 534, and with a local Council of Government, established in accordance with Texas Local Government Code, Chapter 391. These entities have been designated by DADS as local authorities in accordance with Texas Health and Safety Code, §533.035, and, 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.

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

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
DADS conducts at least annual on-site reviews of a local authority’s compliance with the TxHmL program principles for local authorities. Non-compliance with any of the TxHmL Program principles for local authorities 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 local authority.

The 16 TxHmL local authority 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, person-directed plans, and individual service plans. The on-site review also includes evaluation of the local authority’s process of notifying an individual of an offer of enrollment, advising the individual of services available through the waiver, and limitations of services, the local authority’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 a local authority review, the local authority 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 will maintain an electronic “dashboard” reporting deficiencies in carrying out the delegated functions by local authorities, corrective action plans submitted, and remediation of deficiencies. DADS will provide to HHSC a summary report within six months of the end of the waiver year.

Appendix A: Waiver Administration and Operation

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

Function	Medicaid Agency	Other State Operating Agency	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Performance Measure:

A.a.1 Number and percent of data reports specified in the agreement with the State Medicaid Agency that were submitted on time by DADS. N:# of reports delivered on time, year-to-date D: # of reports planned to be delivered on time year-to-date.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Operating Agency

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

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

Data Aggregation and Analysis:

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

Performance Measure:

A.a.2 Number and percent of individuals on the Home and Community-based Services waiver interest list offered TxHmL waiver services on a first-come, first-served basis by DADS. N: # offered slot on a first-come, first-serve basis from the interest list D: # on interest list.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System and Quality Assurance and Improvement DataMart

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

Data Aggregation and Analysis:

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

Performance Measure:

A.a.3 Number and percent of waiver participants enrolled at or below CMS approved level. N: # of participants including aggregate of new enrollees from beginning of waiver

year, D: # of unduplicated participants approved by CMS (Factor C).

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System

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

Data Aggregation and Analysis:

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

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Performance Measure:

A.a.4 Number and percent of service plans at or below the waiver cost limit. N: # of service plans at or below the waiver cost limit, D: # of service plans reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System

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

Data Aggregation and Analysis:

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

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

Performance Measure:

A.a.5 Number and percent of enrollments authorized by DADS that include a valid level of care evaluation as described in the waiver application. N: # of valid levels of care reviewed and authorized by DADS, D: # of enrollments.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System

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

Data Aggregation and Analysis:

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

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

Performance Measure:

A.a.6 Number and percent of service plans that were developed using the process specified in the approved waiver. N: # of service plans that were developed using the process specified in the approved waiver, D: # of service plans developed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System

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

Data Aggregation and Analysis:

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

Performance Measure:

A.a.7 Number and percent of individuals whose waiver services were authorized by DADS prior to service delivery. N: # of individuals whose waiver services were authorized by DADS prior to service delivery, D: # of individuals receiving services.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System and Quality Assurance and Improvement DataMart

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

	<input type="checkbox"/> Other Specify:	
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Data Aggregation and Analysis:

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

Performance Measure:

A.a.8 Number and percent of months that DADS completed utilization review of TxHmL participants. N: # of months that DADS completed utilization review of TxHmL participants, D: # of months.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System and Program Enrollment Access Database

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

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

Data Aggregation and Analysis:

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

Performance Measure:

A.a.9 Number and percent of providers enrolled by DADS according to enrollment procedures. N: # of providers enrolled by DADS according to enrollment procedures, D: # of providers enrolled.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System

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

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

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System

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

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

Data Aggregation and Analysis:

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

Performance Measure:

A.a.11 Number and percent of TxHmL rules implemented by DADS that are approved by the State Medicaid Agency. N: # of TxHmL rules implemented by DADS that are approved by State Medicaid Agency, D: # of rules implemented.

Data Source (Select one):

Other

If 'Other' is selected, specify:

40 Texas Administrative Code, Chapter 9, Subchapter N

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

Data Aggregation and Analysis:

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

Performance Measure:

A.a.12 Number and percent of months that DADS provides HHSC with updated data related to the delegated functions. N: # of months required data is received . D: 12 months.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

	Specify:
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- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

In accordance with 42 CFR Sec. 431.10 (e), the single State Medicaid Agency retains administrative authority over the waiver program. The State develops the initial waiver, subsequent amendments, CMS 372 reports and all state rules for waiver program operations. The operating agency conducts on-site reviews of the local authorities. Additionally, the State is actively involved in program design changes such as the implementation of consumer direction options and in the development of quality assurance activities. The State holds regular status and update meetings directed at evaluating current quality systems and identifying and prioritizing enhancements.

b. Methods for Remediation/Fixing Individual Problems

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

Individual problems may be discovered during monitoring activities by the State or any of the entities that have been delegated certain functions within the performance measures of this Appendix. Department of Aging and Disability Services responsibilities for TxHmL include:

- *enrolling individuals appropriately,
- *approving clinical eligibility for appropriate level of care,
- *approving individual service plans,
- *enrolling qualified providers,
- *executing HHSC/DADS Texas Medicaid Provider Agreements,
- *conducting prior authorization and utilization management responsibilities,
- *adhering to requirements regarding rule promulgation and policy changes,
- *managing waiver enrollment and expenditures within approved limits, and
- *submitting required reports.

If HHSC determines that DADS has not fulfilled these responsibilities within State-established timeframes, HHSC can employ a variety of mechanisms for resolving issues with performance. These mechanisms have varying levels of formality, and include:

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

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

****Elevated conversations:** If an issue is urgent or chronic and is not resolved through informal communication or through discussion at Waiver Strategic Planning meetings, HHSC staff will bring the issue to the attention of HHSC management. This is the final stage of informal communication and is an attempt to resolve issues without creating a formal action memo.

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

If the State discovers that the local authority has not:

- *enrolled individuals appropriately,
- *managed waiver enrollment within approved limits,
- *assessed clinical eligibility for appropriate level of care, or
- *completed a individual service plan,

it will remediate the deficiency with the local authority. The remediation activities are progressive and appropriate to the potential or actual client impact and include, but are not limited to, correcting noted deficiency, corrective action plan, financial and administrative sanctions, vendor hold, and provider termination. Sanctions are documented by the Survey and Certification Unit and the Sanction Action Review Committee.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- No
- Yes

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="checkbox"/> Aged or Disabled, or Both - General					

<input type="checkbox"/>	Aged				<input type="checkbox"/>
<input type="checkbox"/>	Disabled (Physical)				
<input type="checkbox"/>	Disabled (Other)				
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
<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 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="checkbox"/> Mental Illness					
<input type="checkbox"/>	Mental Illness				
<input type="checkbox"/>	Serious Emotional Disturbance				

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

Eligible individuals:

1. Meet the level of care I criteria for intermediate care facilities as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter E and have had a determination of an intellectual and developmental disability 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 Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter N, §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 intermediate care facility.

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

- No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

- Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage:

- Other**

Specify:

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

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

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

This waiver is intended to serve persons who 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 cost limit specified by the State is *(select one):*

- The following dollar amount:**

Specify dollar amount: 17000

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

|

|

Appendix B: Participant Access and Eligibility

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

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

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

The waiver is intended to serve individuals who would require institutionalization in an intermediate care facility without the services and supports available to them through the waiver. All waiver individuals must have a plan of care at a cost within the cost ceiling (\$17,000). For Texas Home Living individuals with needs that exceed the cost limit, the State has a process to ensure their needs are met. The process includes examining third-party resources, possible transition to another waiver, or institutional services.

An applicant 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 Title 1 of the Texas Administrative Code Chapter 357, Subchapter A. DADS must send written notification to the individual or the individual's legally authorized representative, 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*):
- The participant is referred to another waiver that can accommodate the individual's needs.**
 - Additional services in excess of the individual cost limit may be authorized.**

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

Other safeguard(s)

Specify:

If an individual has 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, DADS evaluates the individual's needs to ensure the individual's health and welfare by any one or combination of the following:

- 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 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 community-based service program for which the individual may be eligible;
- The individual will be assisted in seeking admission to an intermediate care facility, if appropriate; and
- The individual will be informed of and given the opportunity to request a fair hearing in accordance with Title 1 of the Texas Administrative Code Chapter 357, Subchapter A, if the State proposes to terminate the individual’s waiver eligibility.

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	6026
Year 2	6026
Year 3	6026
Year 4	6026
Year 5	6026

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	5738
Year 2	5738
Year 3	5738
Year 4	5738
Year 5	5738

Appendix B: Participant Access and Eligibility

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

- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):
- Not applicable. The state does not reserve capacity.**
 - The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

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

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

Select one:

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

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

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

A local authority must maintain an up-to-date interest list of Home and Community-based Services (HCS) program (HCBSW # 0110) applicants living in the local authority's service area. The local authority enters the individual's name into the Client Assignment and Registration system. As the local authorities enter the individuals' names, the Client Assignment and Registration system organizes the entries into chronological order. DADS, in turn, maintains a statewide interest list for the HCS program comprised of the names entered into the Client Assignment and Registration system by the local authorities. DADS does not maintain a separate interest list for the TxHmL program but instead assigns a TxHmL designation to individuals already listed on the HCS interest list in the Client Assignment and Registration system.

DADS determines the number of TxHmL waiver slots that will be allocated to each local authority.

DADS and the local authorities coordinate TxHmL program vacancies as they occur, either through waiver slot attrition or the creation of new TxHmL slots. The local authority offers the TxHmL program vacancy to the applicant or legally authorized representative whose name is first on the interest list for the HCS program. The local authority reviews the applicant's Medicaid type in addition to other TxHmL program requirements to determine if the applicant is eligible for the TxHmL program.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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

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

2. **Miller Trust State.**

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

- No
 Yes

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

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

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

Select one:

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

Specify percentage:

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

Specify:

All other categorically needy groups covered under the State Plan except for the special groups covered under 42 CFR 435.217, 435.211 and 435.236.

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:**

Select one:

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

Specify percentage:

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

Specify dollar amount:

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

Select one:

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to

individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

reasonable indication of the need for services:

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

- Other
Specify:

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.

The required intermediate care facility level of care I is defined in Title 40 of the Texas Administrative Code Part 1, Chapter 9, Subchapter E, (relating to intermediate care facility programs) as follows:

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

(1) Meet the following criteria:

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

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

The level of care is assigned based on information submitted electronically by the local authority providing service coordination to the individual via the Client Assignment and Registration system utilizing the Mental Retardation/Related Condition Assessment. The Mental Retardation/Related Condition Assessment includes all factors that are assessed in evaluating a level of care determination: diagnostic information that includes age of onset of the condition, results of standardized intelligence testing and assessments of adaptive behavior, measures from the Inventory for Client and Agency Planning, and behavioral status.

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

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

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

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

The local authority completes the Mental Retardation/Related Condition Assessment and requests a level of care determination for an applicant or annually for an enrolled individual by electronically submitting the initial or renewal Mental Retardation/Related Condition Assessment, via the Client Assignment and Registration system database system, indicating the recommended level of care. The process for evaluation and reevaluation are the same, except the submission of the Mental Retardation/Related Condition Assessment is done by the program provider.

A level of care determination must be made by DADS in accordance with criteria specified in B-6:1 of this Appendix, and is assigned based on information submitted electronically via the Client Assignment and Registration system utilizing the Mental Retardation/Related Condition Assessment. Information on the Mental Retardation/Related Condition Assessment must be supported by current data obtained from standardized evaluations and formal assessments that measure physical, emotional, social, and cognitive factors.

The local authority must maintain the signed Mental Retardation/Related Condition Assessment and documentation supporting the recommended level of care in the applicant's or individual's record. The electronically transmitted Mental Retardation/Related Condition Assessment must contain information identical to that on the signed Mental Retardation/Related Condition Assessment.

DADS must approve and enter the appropriate level of care into the Client Assignment and Registration system or send written notification to the service coordinator that a level of care has been denied. A level of care determination is valid for 364 calendar days after the level of care 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*):

- Every three months**
- Every six months**

- Every twelve months**
- Other schedule**
Specify the other schedule:

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

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

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

The State employs the following procedures to ensure timely reevaluations of level of care:

1. Edits in the automated Client Assignment and Registration system; and
2. Annual review of local authorities 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 §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records of evaluations and re-evaluations of level of care are maintained in the following locations:

DADS, the operating agency; local authorities; and TxHmL program providers.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

B.a.1 Number and percent of applicants whose initial level of care was completed prior to the receipt of services. N: number of new enrollees whose level of care was completed prior to receipt of first service, D: number of new enrollees.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration system and Program Enrollment Access database

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:

B.b.1 Number and percent of enrolled participants whose level of care is re-evaluated annually. N: number of enrolled participants whose level of care is re-evaluated annually by DADS, D: number of enrolled participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration system and Quality Assurance and Improvement DataMart

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

B.c.1 Number and percent of participants' initial level of care determination forms that were completed as required by DADS. N: number of new participants'

initial level of care determination forms that were completed as required by DADS, D: number of new participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration system and Quality Assurance and Improvement DataMart

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

Data Aggregation and Analysis:

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

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

Performance Measure:

B.c.2 Number and percent of participants' annual level of care determination forms that were completed as required by DADS. N: number of enrolled participants' annual level of care determination forms that were completed as required by DADS, D: number of enrolled participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration system and Quality Assurance and Improvement DataMart

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

Data Aggregation and Analysis:

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

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

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Following the acceptance of an offer of TxHmL program services by an individual or his/her legally authorized representative or family, a local authority collects documentation of the individual’s eligibility for an intermediate care facility level of care and completes the Mental Retardation/Related Condition Assessment form. The local authority must complete and submit the form electronically to the State through the Client Assignment and Registration system. The State approves or denies the level of care submitted. The Client Assignment and Registration 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.

b. Methods for Remediation/Fixing Individual Problems

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

The Client Assignment and Registration system produces daily reports of all pending level of care determinations. This report is used to initiate reviews of all pending levels of care. The Client Assignment and Registration system prevents the delivery of services prior to the State's authorization of the level of care. DADS also has a process for supervisory review of a sample of level of care determinations made each quarter by DADS staff.

A level of care must be approved for each individual prior to service delivery. Services delivered prior to the initial level of care or during the time frame when a level of care has expired are not reimbursed by DADS. DADS approves all levels of care and verifies that they are developed using the prescribed tools and processes. If the State determined that a level of care was submitted that did not utilize the approved instruments and processes, it would be returned to the local authority for correction prior to being approved. Providers are not paid for services until the level of care is completed.

- ii. **Remediation Data Aggregation**

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

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

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

c. Timelines

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

- No**
- Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

A local authority 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. 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 §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The local authority retains the Freedom of Choice Verification Form in the applicant's record.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

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.

Local authority service coordinators and TxHmL program providers must assure that interpreter services are available to individuals during service planning and service delivery.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Day Habilitation		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Extended State Plan Service	Prescription Medications		
Supports for Participant Direction	Financial Management Services		
Supports for Participant Direction	Support Consultation Services		
Other Service	Adaptive Aids		
Other Service	Audiology		
Other Service	Behavioral Support		
Other Service	Community Support		
Other Service	Dental		
Other Service	Dietary		
Other Service	Employment Assistance		
Other Service	Minor Home Modifications		
Other Service	Occupational Therapy		
Other Service	Physical Therapy		
Other Service	Skilled Nursing		
Other Service	Speech/Language Therapy		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Day Habilitation

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):

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 the individual 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 individual’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 six hours a day, five days per week on a regularly scheduled basis.

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.

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.).

Day habilitation may not be provided to a individual at the same time supported employment, respite, or community support is provided.

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

N/A

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer Directed Services – Direct Service Provider
Agency	Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Day Habilitation

Provider Category:

Individual

Provider Type:

Consumer Directed Services – Direct Service Provider

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

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 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.

The provider cannot be the individual's legal guardian or the spouse of the legal guardian.

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

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

The provider of day habilitation must complete initial and periodic training provided by the individual/employer in accordance with 40 Texas Administrative Code §9.579(d), (relating to Certification Principles: Qualified Personnel).

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual employer and consumer directed services agency
DADS staff

Frequency of Verification:

Prior to hiring

Biennial on-site reviews

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

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

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

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

The provider of day habilitation must complete initial and periodic training provided by the program provider in accordance with 40 Texas Administrative Code §9.579(d), (relating to Certification Principles: Qualified Personnel).

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency

DADS staff

Frequency of Verification:

Prior to hiring

Annual on-site reviews

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

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):

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

Respite will be provided in an individual's home or family home and in Home and Community-based Services waiver program foster/companion care home, Home and Community-based Services waiver group home, in the respite provider's home, or in a group respite facility operated by a certified waiver program provider.

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

All other waiver and non-waiver services indicated on the individual's service plan may be provided during the period of respite except that hourly-reimbursed respite may not be provided at the same time Community Support, Supported Employment or Day Habilitation is provided. Federal Financial Participation (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 cannot be provided in an institution such as a nursing facility, intermediate care facility for individuals with intellectual disabilities, or a hospital.

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer Directed Services – Direct Service Provider
Agency	Agencies holding a TxHmL Provider Agreement

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Consumer Directed Services – Direct Service Provider

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

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.

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

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

The provider must not live with the individual.

The provider cannot be the participant's legal guardian or the spouse of the legal guardian.

The provider of respite must complete initial and periodic training provided by the participant/employer in accordance with 40 Texas Administrative Code §9.579(d), (relating to Certification Principles: Qualified Personnel).

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant employer and consumer directed service agency

DADS staff

Frequency of Verification:

Prior to hiring

Biennial on-site reviews

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License (*specify*):

N/A

Certificate (*specify*):

N/A

Other Standard (*specify*):

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.

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

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

The provider must not live with the individual.

The provider of respite must complete initial and periodic training provided by program provider in accordance with 40 Texas Administrative Code §9.579(d), (relating to Certification Principles: Qualified Personnel.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency

DADS staff

Frequency of Verification:

Prior to hiring

Annual on-site reviews

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

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):

Supported employment provides ongoing 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 three 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.

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.

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.).

Federal financial participation will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- (A) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
- (B) Payments that are passed through to users of supported employment programs; or
- (C) Payments for training that is not directly related to an individual's supported employment program.

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

N/A

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer Directed Services – Direct Service Provider
Agency	Agencies holding a TxHmL Provider Agreement

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Individual

Provider Type:

Consumer Directed Services – Direct Service Provider

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

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

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

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

The provider cannot be the participant's legal guardian or the spouse of the legal guardian.

The provider of supported employment must complete initial and periodic training provided by the participant/employer in accordance with 40 Texas Administrative Code §9.579(d), (relating to Certification Principles: Qualified Personnel).

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant employer and consumer directed service agency

DADS staff

Frequency of Verification:

Prior to hiring

Biennial on-site reviews

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (*specify*):

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

Transportation of individuals must be provided in accordance with applicable state laws. Assisting with tasks delegated by a registered nurse must be in accordance with state law.

The provider of supported employment must complete initial and periodic training provided by the program provider in accordance with Title 40 of the Texas Administrative Code, §9.579(d), (relating to Certification Principles: Qualified Personnel).

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency
DADS staff

Frequency of Verification:

Prior to hiring
Annual on-site reviews

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Prescription Medications

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*):

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:

N/A

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Pharmacies holding a Medicaid Provider Agreement—Vendor Drug with Texas Health and Human Services Commission (HHSC)

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Prescription Medications

Provider Category:

Individual

Provider Type:

Pharmacies holding a Medicaid Provider Agreement—Vendor Drug with Texas Health and Human Services Commission (HHSC)

Provider Qualifications

License (specify):

Pharmacy
 Texas State Board of Pharmacy

Certificate (specify):

N/A

Other Standard (specify):

Must hold Vendor Drug Provider Agreement with HHSC.

The provider must complete training as required by HHSC.

Verification of Provider Qualifications

Entity Responsible for Verification:

Texas State Board of Pharmacy

Frequency of Verification:

Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

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

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

Service Definition (Scope):

Financial management services provides assistance to individuals with managing funds associated with the services elected for self-direction. The service includes initial orientation and ongoing training related to responsibilities of being an employer and adhering to legal requirements for employers. The financial management services provider, referred to as the consumer directed services agency, also provides assistance in the development, monitoring and revision of the individual’s budget for each service component delivered through the consumer directed services option and must maintain a separate account for each individual’s budget. The consumer directed services agency provides assistance in determining staff wages and benefits subject to State limits, assistance in hiring by verifying employees’ citizenship status and qualifications, and conducting required background checks. The consumer directed services agency verifies and maintains documentation of employee qualifications, including citizenship status, and documentation of services delivered. The consumer directed services agency 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 financial management services provider tracks disbursement of funds and provides periodic reports to the individual of all expenditures and the status of the individual’s consumer directed services budget.

The consumer directed services agency must not provide service coordination to the individual.

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

n/a

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Consumer directed services agencies contracted to provide financial management services.

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction

Service Name: Financial Management Services

Provider Category:

Agency

Provider Type:

Consumer directed services agencies contracted to provide financial management services.

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (*specify*):

Private entities furnish financial management services. These entities, called consumer directed services agencies, are procured through an open enrollment process and the State has Medicaid provider agreements with multiple entities (consumer directed services agencies) to provide financial management services to individuals across the state. Through a delegation arrangement, DADS executes a contract with the required elements of the HHSC/DADS Texas Medicaid provider agreement on behalf of HHSC.

Prior to contracting with DADS to provide financial management services, a consumer directed services agency must comply with the requirements for delivery of financial management services, including attending a DADS mandatory three-day training session. Topics covered in the training session include: contracting requirements and procedures, consumer directed services agency responsibilities, consumer/employer responsibilities, case manager/service coordinator responsibilities, enrollment, transfer, suspension and termination of the consumer directed services option, employer budgets, reporting abuse, neglect and exploitation allegations, oversight of consumer directed services, contract compliance and financial monitoring. The required training materials include the definition and responsibilities of a vendor fiscal/employer agent in accordance with IRS Revenue Procedure 70-6, 1970-1 C.B. 420 and an explanation of fiscal employer agent based on Section 3504 of the IRS code and state tax (unemployment) requirements as a vendor fiscal/employer agent. The training also covers IRS Forms SS-4 and 2678. The rules for the consumer directed services option, located at Title 40 of the Texas Administrative Code, Chapter 41, require consumer directed services agencies to act as vendor fiscal/employer agents along with describing responsibilities such as the revocation of IRS Form 2678 if the individual terminates the consumer directed services option or transfers to another consumer directed services agency.

The consumer directed services agency must not be the individual's legal guardian, the spouse of the individual's legal guardian, the individual's designated representative, or the spouse of the individual's designated representative.

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

DADS staff

Frequency of Verification:

Biennial on-site reviews

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Support Consultation Services

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

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

Service Definition (*Scope*):

Support consultation is an optional service component that offers practical skills training and assistance to enable an individual or his/her legally authorized representative to successfully direct those services the individual or the legally authorized representative-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 backup 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.

Support consultation may be provided by a qualified individual associated with a consumer directed services agency selected by the participant or by an independent individual hired by the participant.

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

N/A

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer Directed Services – Direct Service Provider

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Consumer Directed Services – Direct Service Provider

Provider Qualifications

License (*specify*):

N/A

Certificate (*specify*):

Individual provider must have certification of successful completion of required training conducted or approved by DADS.

Other Standard (*specify*):

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), have 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.

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.

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

Support consultation may be provided by a qualified individual associated with a consumer directed services agency selected by the participant or by an independent individual hired by the participant.

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant employer and consumer directed services agency
DADS staff

Frequency of Verification:

Prior to completing service agreement

Biennial on-site reviews

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adaptive Aids

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

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

Service Definition (Scope):

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 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 five-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 five-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

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
- (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

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 authority, and other natural supports or seeking funding through non-waiver resources local 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 community-based service program for which the individual may be eligible;
- The individual will be assisted in seeking admission to an intermediate care facility, if appropriate; and
- The individual will be informed of and given the opportunity to request a fair hearing in accordance with 1 Texas Administrative Code 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.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a TxHmL Provider Agreement
Individual	Consumer Directed Services – Direct Service Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adaptive Aids

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency

DADS staff

Frequency of Verification:

Prior to completing service agreement

Annual on-site reviews

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adaptive Aids

Provider Category:

Individual

Provider Type:

Consumer Directed Services – Direct Service Provider

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant employer and consumer directed service agency

DADS staff

Frequency of Verification:

Prior to completing service agreement

Biennial on-site reviews

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Audiology

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):

The audiology service component provides assessment and treatment by licensed audiologists, and includes training and consultation with an individual's family members or other support providers.

The audiology service includes:

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

Audiology services are 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 audiology benefits through the Texas Health Steps--Comprehensive Care Program (EPSDT) before audiology services may be provided under this waiver.

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

N/A

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer Directed Services – Direct Service Provider
Agency	Agencies holding a TxHmL Provider Agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Audiology

Provider Category:

Individual

Provider Type:

Consumer Directed Services – Direct Service Provider

Provider Qualifications

License (specify):

Speech/Language Pathologist, Audiologist
 (Texas Occupations Code)

Certificate (specify):

N/A

Other Standard (specify):

The provider cannot be the participant's legal guardian or the spouse of the legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant employer and consumer directed services agency

DADS staff

Frequency of Verification:

Prior to completing service agreement; prior to expiration of license

Biennial on-site reviews

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Audiology

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License (specify):

Speech/Language Pathologist, Audiologist
 (Texas Occupations Code)

Certificate (specify):

N/A

Other Standard (specify):

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency

DADS staff

Frequency of Verification:

Prior to completing service agreement; prior to expiration of license

Annual on-site reviews

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavioral Support

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):

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.

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.

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

N/A

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a TxHmL Provider Agreement

Individual | Consumer Directed Services – Direct Service Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License (specify):

Psychologist
(Texas Occupations Code Chapter 501)

Psychological Associate
(Texas Occupations Code Chapter 501)

Certificate (specify):

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.)

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency

DADS staff

Frequency of Verification:

Prior to completing service agreement; prior to expiration of license or certification
Annual on-site reviews

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support

Provider Category:

Individual

Provider Type:

Consumer Directed Services – Direct Service Provider

Provider Qualifications

License (specify):

Psychologist
(Texas Occupations Code Chapter 501)

Psychological Associate
(Texas Occupations Code Chapter 501)

Certificate (specify):

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.)

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant employer and consumer directed services agency

DADS staff

Frequency of Verification:

Prior to completing service agreement; prior to expiration of license or certification

Biennial on-site reviews

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Support

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*):

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer Directed Services – Direct Service Provider
Agency	Agencies holding a TxHmL Provider Agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Support

Provider Category:

Individual

Provider Type:

Consumer Directed Services – Direct Service Provider

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

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 served.

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

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

The provider must not live with the individual.

The provider cannot be the participant's legal guardian or the spouse of the legal guardian.

The provider of community support services must complete initial and periodic training provided by the participant/employer in accordance with 40 Texas Administrative Code §9.579(d), (relating to Certification Principles: Qualified Personnel).

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant employer and consumer directed services agency

DADS staff

Frequency of Verification:

Prior to hiring

Biennial on-site reviews

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Support

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

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 served.

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

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

The provider must not live with the individual.

The provider of community support must complete initial and periodic training provided by the program provider in accordance with 40 Texas Administrative Code §9.579(d), (relating to Certification Principles: Qualified Personnel).

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency

DADS staff

Frequency of Verification:

Prior to hiring

Annual on-site reviews

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Dental

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):

Elements of this component include the following:

- (A) Emergency dental treatment. Those procedures necessary to control bleeding, relieve pain, and eliminate acute infection; operative procedures that are required to prevent the imminent loss of teeth; and treatment of injuries to the teeth or supporting structures.
- (B) Preventive dental treatment. Examinations, oral prophylaxes, and topical fluoride applications.
- (C) Therapeutic dental treatment. Treatment that includes, but is not limited to, pulp therapy for permanent and primary teeth; restoration of carious permanent and primary teeth; maintenance of space; and limited provision of removable prostheses when masticatory function is impaired, when an existing prosthesis is unserviceable, or when aesthetic considerations interfere with employment or social development.
- (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.

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

Dental treatment is provided under this waiver when no other financial resource for such treatment is available or when other available resources have been exhausted. 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.

The total amount allowable for the dental treatment component is limited to a maximum expenditure of \$1,108.06 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 authority, local community agencies and other natural supports.

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 community-based service program for which the individual may be eligible;
- The individual will be assisted in seeking admission to an intermediate care facility, if appropriate; and
- The individual will be informed of and given the opportunity to request a fair hearing in accordance with 1 Texas Administrative Code Part 15, Chapter 357, Subchapter A, if the State proposes to terminate the individual’s waiver eligibility.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a TxHmL Provider Agreement
Individual	Consumer Directed Services – Direct Service Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Dental

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License (specify):

Dentist

(Texas Occupations Code Chapter 251)

Certificate (specify):

N/A

Other Standard (specify):

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency

DADS staff

Frequency of Verification:

Prior to completing service agreement

Annual on-site reviews

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Dental

Provider Category:

Individual

Provider Type:

Consumer Directed Services – Direct Service Provider

Provider Qualifications

License (specify):

Dentist

(Texas Occupations Code Chapter 251)

Certificate (specify):

N/A

Other Standard (specify):

The provider cannot be the participant's legal guardian or the spouse of the legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant employer and consumer directed services agency

DADS staff

Frequency of Verification:

Prior to completing service agreement; prior to expiration of license

Biennial on-site reviews

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Dietary

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):

The Dietary service component assists individuals in meeting their basic and/or special therapeutic nutritional needs. Medically oriented nutritional services are especially important to ensure and maintain the health of persons on modified diets required by a disability and those requiring enteral or parenteral nutrition regimens. The dietary service component consists of assessment and treatment by licensed dietitians and includes training and consultation with an individual’s family members or other support providers.

Services include:

- Screening and assessment;
- Development of therapeutic treatment plans;
- Direct therapeutic intervention;and
- Participating on the interdisciplinary team, when appropriate.

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

Dietary services 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 benefits through the Texas Health Steps--Comprehensive Care Program (EPSDT) before services may be provided under this waiver.

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a TxHmL Provider Agreement
Individual	Consumer Directed Services – Direct Service Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietary

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License (specify):

Dietitian

(Texas Occupations Code Chapter 701)

Certificate (specify):

N/A

Other Standard (specify):

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency

DADS staff

Frequency of Verification:

Prior to completing service agreement; prior to expiration of license

Annual on-site reviews

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Dietary

Provider Category:

Individual

Provider Type:

Consumer Directed Services – Direct Service Provider

Provider Qualifications

License (specify):

Dietitian

(Texas Occupations Code Chapter 701)

Certificate (specify):

N/A

Other Standard (specify):

The provider cannot be the participant's legal guardian or the spouse of the legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant employer and consumer directed services agency

DADS staff

Frequency of Verification:

Prior to completing service agreement; prior to expiration of license

Biennial on-site reviews

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional

service not specified in statute.

Service Title:

Employment Assistance

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):

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.

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.).

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

N/A

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer Directed Services – Direct Service Provider
Agency	Agencies holding a TxHmL Provider Agreement

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Employment Assistance

Provider Category:

Individual

Provider Type:

Consumer Directed Services – Direct Service Provider

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

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.

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

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

The provider cannot be the participant's legal guardian or the spouse of the legal guardian.

The provider of employment assistance must complete initial and periodic training provided by the participant/employer in accordance with 40 Texas Administrative Code §9.579(d), (relating to Certification Principles: Qualified Personnel).

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant employer and consumer directed services agency

DADS staff

Frequency of Verification:

Prior to hiring

Biennial on-site reviews

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Employment Assistance

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

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.

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

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

The provider of employment assistance services must complete initial and periodic training provided by the program provider in accordance with 40 Texas Administrative Code §9.579(d), (relating to Certification Principles: Qualified Personnel).

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency
DADS staff

Frequency of Verification:

Prior to hiring

Annual on-site reviews

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Minor Home Modifications

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

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

Service Definition (Scope):

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.

Excluded are those adaptations or improvements to the home, which are of general utility, and are not of direct medical or remedial benefit to the individual. Examples of items excluded are installation of carpeting, roof repair, installation of central air conditioning, major home renovations, and construction of additional rooms or other modifications, which add to the total square footage of the home.

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 Americans with Disabilities Act 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 authority, and other natural supports or seeking funding through non-waiver resources local 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 community-based service program for which the individual may be eligible;
- The individual will be assisted in seeking admission to an intermediate care facility, if appropriate; and
- The individual will be informed of and given the opportunity to request a fair hearing in accordance with Title 1 of the Texas Administrative Code, Chapter 357, Subchapter A, if the State proposes to terminate the individual's waiver eligibility.

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

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

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

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

Provider Specifications:

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Provider Category	Provider Type Title
Individual	Consumer Directed Services – Direct Service Provider
Agency	Agencies holding a TxHmL Provider Agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Minor Home Modifications

Provider Category:

Individual

Provider Type:

Consumer Directed Services – Direct Service Provider

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

Qualified contractors provide minor home modifications in accordance with state and local building codes and other applicable regulations.

The provider cannot be the participant's legal guardian or the spouse of the legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant employer and consumer directed services agency

DADS staff

Frequency of Verification:

Prior to completing service agreement

Biennial on-site reviews

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Minor Home Modifications

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

Qualified contractors provide minor home modifications in accordance with state and local building codes and other applicable regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency

DADS staff

Frequency of Verification:

Prior to completing service agreement
Annual on-site reviews

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Occupational Therapy

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*):

Occupational Therapy services consists of the full range of activities provided by a licensed occupational therapist, or a licensed occupational therapy assistant, under the direction of a licensed occupational therapist, within the scope of state licensure. Texas assures that Occupational Therapy is cost-effective and necessary to avoid institutionalization. Individuals who are under 21 years of age must access occupational therapy benefits through the Texas Health Steps--Comprehensive Care Program before Occupational Therapy may be provided under this waiver. The scope of Occupational Therapy services offered in this waiver exceeds the State Plan occupational therapy benefit. Under the waiver, Occupational Therapy will be provided to maintain the individual's optimum condition.

Services include:

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

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

Occupational Therapy is provided under this waiver when no other financial resource for such therapy is available or when other available resources have been used. Participants who are under 21 years of age must first access occupational therapy benefits through the Texas Health Steps--Comprehensive Care Program (EPSDT) before services may be provided under this waiver.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a TxHmL Provider Agreement
Individual	Consumer Directed Services – Direct Service Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License (specify):
 Occupational Therapist
 (Texas Occupations Code Chapter 454)

Certificate (specify):
 N/A

Other Standard (specify):
 N/A

Verification of Provider Qualifications

Entity Responsible for Verification:
 Provider agency

DADS staff

Frequency of Verification:
 Prior to completing service agreement; prior to expiration of license

Annual on-site reviews

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Occupational Therapy

Provider Category:

Individual

Provider Type:

Consumer Directed Services – Direct Service Provider

Provider Qualifications

License (specify):
 Occupational Therapist
 (Texas Occupations Code Chapter 454)

Certificate (specify):
 N/A

Other Standard (specify):
 The provider cannot be the participant's legal guardian or the spouse of the legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:
 Participant employer and consumer directed services agency

DADS staff

Frequency of Verification:

Prior to completing service agreement; prior to expiration of license

Biennial on-site reviews

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Physical Therapy

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):

Physical Therapy services consist of the full range of activities provided by a licensed physical therapist, or a licensed physical therapy assistant under the direction of a licensed physical therapist, within the scope of his state licensure. Individuals who are under 21 years of age must access physical therapy benefits through the Texas Health Steps--Comprehensive Care Program before Physical Therapy may be provided under this waiver. The scope of Physical Therapy services offered in this waiver exceeds the state plan physical therapy benefit. Under the waiver, Physical Therapy will be provided to maintain the individual's optimum condition.

Services include:

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

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

Physical Therapy is provided under this waiver when no other financial resource for such therapy is available or when other available resources have been used. Participants who are under 21 years of age must first access physical therapy benefits through the Texas Health Steps--Comprehensive Care Program (EPSDT) before therapy may be provided under this waiver.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a TxHmL Provider Agreement
Individual	Consumer Directed Services – Direct Service Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License (specify):

Physical Therapist
 (Texas Occupations Code Chapter 453)

Certificate (specify):

N/A

Other Standard (specify):

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency

DADS staff

Frequency of Verification:

Prior to completing service agreement; prior to expiration of license

Annual on-site reviews

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physical Therapy

Provider Category:

Individual

Provider Type:

Consumer Directed Services – Direct Service Provider

Provider Qualifications

License (specify):

Physical Therapist
 (Texas Occupations Code Chapter 453)

Certificate (specify):

N/A

Other Standard (specify):

The provider cannot be the participant's legal guardian or the spouse of the legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant employer and consumer directed services agency

DADS staff

Frequency of Verification:

Prior to completing service agreement; prior to expiration of license

Biennial on-site reviews

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Skilled Nursing

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):

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

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a TxHmL Provider Agreement
Individual	Consumer Directed Services – Direct Service Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License (specify):

Registered Nurse
(Texas Occupations Code Chapter 301)

Licensed Vocational Nurse
(Texas Occupations Code Chapter 301)

Certificate (specify):

N/A

Other Standard (specify):

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency

DADS staff

Frequency of Verification:

Prior to completing service agreement; prior to expiration of license.

Annual on-site reviews

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Skilled Nursing

Provider Category:

Individual

Provider Type:

Consumer Directed Services – Direct Service Provider

Provider Qualifications

License (specify):

Registered Nurse
(Texas Occupations Code Chapter 301)

Licensed Vocational Nurse
(Texas Occupations Code Chapter 301)

Certificate (specify):

N/A

Other Standard (specify):

The provider cannot be the participant's legal guardian or the spouse of the legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant employer and consumer directed services agency

DADS staff

Frequency of Verification:

Prior to completing service agreement; prior to expiration of license.

Biennial on-site reviews

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Speech/Language Therapy

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):

Speech/Language Therapy services consist of the full range of activities provided by a licensed speech/language pathologist, or a licensed associate in speech/language pathology, under the direction of a licensed speech/language pathologist, within the scope of licensure.

Services include:

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

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

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

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer Directed Services – Direct Service Provider
Agency	Agencies holding a HHSC/DADS Texas Medicaid Provider Agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Speech/Language Therapy

Provider Category:

Individual

Provider Type:

Consumer Directed Services – Direct Service Provider

Provider Qualifications

License (specify):

Speech/Language Pathologist, Audiologist
(Texas Occupations Code Chapter 401)

Certificate (specify):

N/A

Other Standard (specify):

The provider cannot be the individual's legal guardian or the spouse of the legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant employer and consumer directed services agency

DADS staff

Frequency of Verification:

Prior to hiring

Biennial on-site reviews

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Speech/Language Therapy

Provider Category:

Agency

Provider Type:

Agencies holding a HHSC/DADS Texas Medicaid Provider Agreement

Provider Qualifications

License (specify):

Speech/Language Pathologist, Audiologist
(Texas Occupations Code Chapter 401)

Certificate (specify):

N/A

Other Standard (specify):

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency

DADS staff

Frequency of Verification:

Prior to completing service agreement; prior to expiration of license

Annual on-site reviews

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- As a waiver service defined in Appendix C-3. Do not complete item C-1-c.**
- As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** Complete item C-1-c.
- As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** Complete item C-1-c.
- As an administrative activity.** Complete item C-1-c.

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

DADS contracts with local community centers, established in accordance with Texas Health and Safety Code, Chapter 534, and with a local Council of Government established in accordance with Texas Local Government Code, Chapter 391. These entities have been designated by DADS as local authorities in accordance with Texas Health and Safety Code, §533.035, and, as part of their contractual responsibilities, provide targeted case management for TxHmL waiver program individuals.

Appendix C: Participant Services

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

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

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

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

Program providers, local authorities, and participant employers must comply with the Texas Health and Safety Code Chapter 250 by taking the following actions regarding applicants, employees, and contractors:

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

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

Providers are required to maintain documentation of the criminal history checks performed.

During on-site reviews of program providers, consumer directed service agencies and local authorities, DADS monitors for completion of criminal history checks as required.

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

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

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

Program providers and participant employers must comply with the Texas Health and Safety Code, Chapters 250 and 253, by taking the following action regarding applicants, employees, and contractors:

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

(B) Search the Employee Misconduct Registry maintained by DADS in accordance with Texas Health and Safety Code Chapter 253, and refrain from employing or contracting with or immediately discharge, a person whose duties would or do involve direct contact with a consumer, and who is designated in the registry as having abused, neglected, or exploited a consumer or has misappropriated a consumer's property.

Program providers, consumer directed services agencies, and local authorities 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.

Appendix C: Participant Services

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

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

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

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

Facility Type	
Three person residence	
Four person residence	

- 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.

TxHmL offers respite services in home settings serving four individuals. These small residential settings are located in Texas community neighborhoods in family homes and are constructed with kitchen areas, living rooms, private bedrooms, and bathrooms. The participants must have access to a telephone, a place for personal belongings and the ability to entertain guests. Four person residences are driven by a service philosophy that emphasizes personal dignity, autonomy, independence, and privacy.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Three person residence

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Employment Assistance	<input type="checkbox"/>
Behavioral Support	<input type="checkbox"/>
Prescription Medications	<input type="checkbox"/>
Community Support	<input type="checkbox"/>
Dietary	<input type="checkbox"/>
Adaptive Aids	<input type="checkbox"/>
Dental	<input type="checkbox"/>
Skilled Nursing	<input type="checkbox"/>
Minor Home Modifications	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>
Respite	<input checked="" type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>
Support Consultation Services	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Audiology	<input type="checkbox"/>
Financial Management Services	<input type="checkbox"/>
Day Habilitation	<input type="checkbox"/>
Speech/Language Therapy	<input type="checkbox"/>

Facility Capacity Limit:

Three

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>

Staff : resident ratios	<input type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Respite services in the TxHmL program can be provided in a three person residence. The provider agency is required to have one individual in the home that receives residential support.

The individuals Level of Need dictates what staffing level is required to ensure the individuals safety within the residential setting. Since the Level of Need varies across individuals, the staff to resident ratio will vary.

DADS Waiver and Certification staff review each provider annually to ensure that all program principles outlined in Title 40 of the Texas Administrative Code, Chapter 9, Subchapter N are being met by the provider.

Program principles that relates to the facility standards for staff: resident ratios is listed below:

Texas Administrative Code, Chapter 9, Subchapter N, Section 9.562, Level of Need Assignment

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Four person residence

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Employment Assistance	<input type="checkbox"/>
Behavioral Support	<input type="checkbox"/>
Prescription Medications	<input type="checkbox"/>
Community Support	<input type="checkbox"/>
Dietary	<input type="checkbox"/>
Adaptive Aids	<input type="checkbox"/>
Dental	<input type="checkbox"/>
Skilled Nursing	<input type="checkbox"/>
Minor Home Modifications	<input type="checkbox"/>

Physical Therapy	<input type="checkbox"/>
Respite	<input checked="" type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>
Support Consultation Services	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Audiology	<input type="checkbox"/>
Financial Management Services	<input type="checkbox"/>
Day Habilitation	<input type="checkbox"/>
Speech/Language Therapy	<input type="checkbox"/>

Facility Capacity Limit:

Four

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

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

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Respite services in the TxHmL program can be provided in a four person residence. In order for a provider agency to operate a four person residence, the provider must seek approval from DADS. The provider agency is required to have one individual in the home that receives residential support.

The individuals Level of Need dictates what staffing level is required to ensure the individuals safety within the residential setting. Since the Level of Need varies across individuals, the staff to resident ratio will vary.

DADS Waiver and Certification staff review each provider annually to ensure that all program principles outlined in Title 40 of the Texas Administrative Code, Chapter 9, Subchapter N are being met by the provider.

Program principles that relates to the facility standards for staff: resident ratios is listed below:

Texas Administrative Code, Chapter 9, Subchapter N, Section 9.562, LON Assignment

Appendix C: Participant Services

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

- d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

● **Other policy.**

Specify:

Relatives and guardians, who are not legally responsible for the individual, and who meet qualifications, may provide TxHmL service components with the following exceptions: 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.

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 consumer directed services agencies require submission of required documentation before paying the provider of services and submitting a billing claim.

During billing and payment reviews of TxHmL program providers and reviews of consumer directed services agencies, DADS staff monitors to determine compliance with policies concerning eligibility of individual providers and completion of required documentation.

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

The following processes are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

In order to obtain a provider agreement as a TxHmL program provider, a provider applicant must apply for such in accordance with Title 40 of the Texas Administrative Code 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.

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.

---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:

- (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
- (B) Comply with all requirements of Title 40 of the Texas Administrative Code, Part 1, Subchapter Q, §9.704.

Upon request of an HCS provider that is certified, DADS may certify 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.

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:

- 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;
- 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), Title 40 of the 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 legally authorized representative'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.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

- a. *Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

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

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

Performance Measure:

C.a.1 Number and percent of new contracted providers who are qualified by licensure, certification or state regulations prior to furnishing services. N: number of new contracted providers who are qualified by licensure, certification or state regulations prior to furnishing services, D: number of new contracted providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Quality Assurance and Improvement DataMart

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

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

Data Aggregation and Analysis:

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

Performance Measure:

C.a.2 Number and percent of providers continuing to meet applicable licensure/certification requirements following initial enrollment. N: number of providers continuing to meet applicable licensure/certification requirements following initial enrollment, D: number of active contracts up for renewal.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System

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

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

Data Aggregation and Analysis:

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

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

For each performance measure/indicator the State will use to assess compliance with the statutory

assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

C.b.1 Number and percent of new non-licensed/non-certified provider applicants who met initial waiver provider qualifications. N: number of new non-licensed/non-certified provider applicants who met initial waiver provider qualifications, D: Total number of new non-licensed/non-certified providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System

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

Data Aggregation and Analysis:

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

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

Performance Measure:

C.b.2 Number and percent of non-licensed/non-certified provider applicants who continue to meet waiver provider qualifications. N: number of non-licensed/non-certified provider applicants who continue to meet waiver provider qualifications, D: number of active contracts up for renewal.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System

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

	<input type="checkbox"/> Other Specify:	
--	---	--

Data Aggregation and Analysis:

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

- c. **Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

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

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

Performance Measure:

C.c.1 Number and percent of providers meeting provider training requirements.

N: number of providers meeting provider training requirements, D: number of providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System

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

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

Data Aggregation and Analysis:

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

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

During initial on-site and annual certification reviews of TxHmL program providers, DADS verifies that all minimum provider qualifications are met and required training has been accomplished through personnel records review.

b. Methods for Remediation/Fixing Individual Problems

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

When the State detects provider non-compliance with the program certification principles the agency requires the provider to implement corrective action. Following certification reviews, all providers receive a written certification review report that details the specific areas of non-compliance found during the review and includes instruction regarding the provider’s responsibility with regard to the areas of deficiency. The State then conducts follow-up activities in accordance with TxHmL Program Provider Review Procedures and Consumer Directed Services Agency Review Procedures to ensure corrective action has been implemented. When requested, the State will provide technical assistance.

- ii. **Remediation Data Aggregation**

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

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

c. Timelines

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

- No**
- Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable -** The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

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 \$13,600 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 \$3,400 per year per individual unless DADS approves an exception to the service limit.

As demonstrated in the CMS-372 annual report 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. 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 \$17,000 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 waiver application.

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

- Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person-directed Plan (PDP)

- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the State**
 Licensed practical or vocational nurse, acting within the scope of practice under State law
 Licensed physician (M.D. or D.O)
 Case Manager (qualifications specified in Appendix C-1/C-3)
 Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- Social Worker.**

Specify qualifications:

- Other**

Specify the individuals and their qualifications:

To support the philosophy of person-directed planning, service plans in TxHmL are actually comprised of three documents. The local authority service coordinator in conjunction with the individual and legally authorized representative is responsible for developing the person-directed plan, which outlines the individual's desired outcomes and goals for waiver services and identifies the service components of the waiver the individual needs to meet their desired outcomes. Service coordinators must be employees of the local authorities to provide service coordination to individuals in this waiver and must meet the following criteria:

1. Have a bachelor's or advanced degree from an accredited college or university with a major in a social, behavioral, or human service field, including psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human development, gerontology, educational psychology, education, and criminal justice; or
2. Have a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma with two years of paid experience as a case manager in a state or federally funded Parent Case Management program or have graduated from Partners in Policy Making, and personal experience as an immediate family member of an individual with an intellectual and developmental disability.

Based on the person-directed plan, the service coordinator, individual, legally authorized representative and the program provider develop the service plan. The service plan identifies the amount needed for each waiver service component that is identified in the person-directed plan.

The program provider, the individual and legally authorized representative develop the implementation plan document. This plan outlines how, through the provision of each waiver service component, the program provider will support the individual to achieve his or her desired outcome for each waiver service component. This plan outlines the schedule for service provision and provides detail regarding how each service component will help achieve the individual's desired outcome for the service.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

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

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

As noted in Appendix C-1 (c), local community centers and a Council of Government are designated as local authorities. A community center, in its role as a local authority, provides service coordination to TxHmL program individuals in accordance with the provisions relating to targeted case management for persons with intellectual and developmental disabilities contained in the approved Texas State Medicaid Plan. Under those provisions, employees of local authorities are authorized to provide targeted case management. Recipients may request a change in service coordinators from the local authority but the service coordinator must be an employee of the local authority serving the geographic area where the recipient receives TxHmL program services.

The community center or local authority may also hold a HHSC/DADS Texas Medicaid 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 individual is prohibited from providing any other direct waiver service to that individual. At the time of a individual's enrollment, the individual's service coordinator informs the individual and the individual's legally authorized representative that the service coordinator may not provide other waiver services to the individual.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development. *Specify:*** (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The service coordinator assures that the applicant/individual and legally authorized representative participate in developing a person-directed plan that meets the individual's identified needs and service outcomes. The service coordinator supports the individual and legally authorized representative in setting goals that address the needs identified during assessment and educating the individual or legally authorized representative about service delivery options and the services available through the TxHmL program to achieve these goals. The person-directed plan must be developed in accordance with "Person Directed Planning and Family Directed Planning Guidelines for Individuals Living in the Community." The service coordinator must inform the applicant/individual or legally authorized representative 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.

The local authority 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 person-directed plan and services due to changes in needs, goals or preferences. At least annually, the service coordinator must present information to the individual or legally authorized representative regarding available waiver services and supports and the available service delivery options.

The service planning team consists of the applicant or individual, legally authorized representative, service coordinator, and other persons such as family members, service providers, or friends chosen or designated by the applicant, individual or legally authorized representative to participate in service planning.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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 person-directed plan process and resulting plan must address the following:

- (A) A description of the needs and preferences identified by the individual and legally authorized representative;
- (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 person-directed plan process identifies and focuses on the desires and needs as identified by the individual and legally authorized representative, and the individual's and legally authorized representative'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 legally authorized representative's participation in the process by encouraging the expression of preferences, goals and ambitions and providing education about the services available through the 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 functioning, specialized therapeutic interventions are completed as the need is identified by the service planning team. The person-directed plan 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 legally authorized representative, and at least annually, the service coordinator must present information to the individual or legally authorized representative regarding available services and supports and the available service delivery options. The service coordinator must also inform the individual or legally authorized representative that the service coordinator will assist the individual or legally authorized representative to transfer the individual's TxHmL program services from one program provider to another program provider or financial management service provider to another program provider or financial management service provider as chosen by the individual or legally authorized representative. The local authority must assure an individual or legally authorized representative is informed of the name of the individual's service coordinator and how to contact the service coordinator.

The applicant/individual and legally authorized representative, service coordinator, and other team members work together to develop a person-directed plan 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 person-directed plan 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.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

During the service planning process, the service coordinator considers information from the individual and legally authorized representative, other service planning team members, and 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 consumer directed services option, the service planning team identifies services critical to the health and welfare of the individual for which a backup plan must be developed, documented in the service plan, and approved by the team. Backup plans may use paid or unpaid service providers, other third party resources and other community resources. State rules governing the TxHmL program (Title 40 of the Texas Administrative Code 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.

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.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Rules governing the TxHmL program (Title 40 of the Texas Administrative Code Part 1, Chapter 9, Subchapter N) require a local authority to:

- (A) provide a list to the individual or legally authorized representative with contact information for all TxHmL program providers in the local authority's local service area;
- (B) assist in educating and securing tools for use by the individual or legally authorized representative in evaluating 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 legally authorized representative; and
- (D) assure that the applicant's or legally authorized representative's choice of a TxHmL program provider is documented, signed by the individual or the legally authorized representative, and retained by the local authority in the applicant's record.

These rules also require local authorities to have a mechanism to assure objectivity in the process it uses to assist an individual or legally authorized representative in the selection of a program provider and a system for training all local authority staff who may assist an individual or legally authorized representative in such process.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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 verifies compliance through a look-behind review process for service plans previously approved by the operating agency and those reviewed on-site during the review.

Appendix D: Participant-Centered Planning and Service Delivery

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

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
 Operating agency
 Case manager
 Other

Specify:

TxHmL program provider

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

Service coordinators employed by local authorities 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 person-directed plan. 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 person-directed plan, 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 legally authorized representative are satisfied with implementation of services;
- whether or not the individual's health and welfare are reasonably assured;
- whether or not the individual or legally authorized representative exercises free choice of providers and accesses non-waiver services including health services; and
- for the participant electing the consumer directed services option, whether or not implementation of the backup 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 legally authorized representative, convening a service planning meeting to resolve problems or 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 individual's backup 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 individual's record that the plan was effective or that revisions were required. The service coordinator assures that a revised backup plan is developed whenever necessary.

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

- b. Monitoring Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of

the participant. *Specify:*

As noted in Appendix C-1 (c), local community centers and Councils of Government are designated as local authorities. A community center, in its role as a local authority, provides service coordination to TxHmL program individuals. 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 individual is prohibited from providing any other direct waiver service to that individual.

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

Local authorities enter into a performance contract with DADS, which prohibits staff providing TxHmL service coordination from providing any other direct "provider" service to the individual through the TxHmL program or other funding source such as state general revenue services, the HCS program (waiver 0110), or the intermediate care facility 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 individuals 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 local authority's role through an annual on-site review during which the local authority's compliance with provisions of the state rules governing the TxHmL program and the performance contract is evaluated.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

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

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

Performance Measure:

D.a.1 Number and percent of participants who had service plans that address participants' assessed needs, including health and safety risk factors. N: Number of participants who have service plans that address participants' assessed needs, including health and safety risk factors D: Number of enrolled participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System

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

Data Aggregation and Analysis:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System and Quality Assurance and Improvement DataMart

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

Data Aggregation and Analysis:

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

	<input type="checkbox"/> Other Specify: _____
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- b. **Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.**

Performance Measures

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

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

Performance Measure:

D.b.1 Number and percent of service plans developed in accordance with policies and procedures. N: # of participants with service plans developed in accordance with policies and procedures D: # of enrolled participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System and Quality Assurance and Improvement DataMart

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

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

Data Aggregation and Analysis:

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

- c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.*

Performance Measures

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

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

Performance Measure:

D.c.1 Number and percent of participants' service plans that are reassessed and renewed annually prior to service plan expiration date. N: # of participants'

service plans that were reassessed and renewed annually prior to service plan expiration date, D: # of enrolled participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System and Quality Assurance and Improvement DataMart

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

Data Aggregation and Analysis:

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

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

- d. **Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.**

Performance Measures

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

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

Performance Measure:

D.d.1 Number and percent of participants whose services are delivered in accordance with their service plan. N: # of participants whose services are delivered in accordance with their service plan, D: # of participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System and Records review, on-site

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

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

Data Aggregation and Analysis:

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

- e. **Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.**

Performance Measures

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

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

Performance Measure:

D.e.1 Number and percent of participants who are afforded choice between waiver services and institutional care. N: # of participants who are afforded choice between waiver services and institutional care, D: # of enrolled participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System

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

Data Aggregation and Analysis:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System

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

Data Aggregation and Analysis:

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

	Specify:
--	----------

Performance Measure:

D.e.3 Number and percent of participants who are afforded choice among waiver services. N: # of participants who are afforded choice among waiver services, D: # of enrolled participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System

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

Data Aggregation and Analysis:

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

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

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Service coordinators employed by a local authority facilitate individual service planning at the time of enrollment. The initial service plan is developed using a person-directed planning process. The service coordinator convenes a service planning team that must include the individual and, if applicable, the individual's legally authorized representative and, at the invitation of the individual or legally authorized representative, other individuals important in developing the individual service plan such as providers of waiver or non-waiver services and family or friends. At the time of enrollment, the individual or legally authorized representative chooses a TxHmL program provider from all program providers serving their geographical area. The local authority assigns a service coordinator, who is responsible for convening the individual's service planning team and assuring the service plan is reviewed and revised at least annually and whenever indicated by changes in the individual's service needs. Findings from the National Core Indicators survey will be used for trending and analysis.

b. Methods for Remediation/Fixing Individual Problems

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

When the State detects provider non-compliance with the program certification principles, it requires the provider to implement corrective action. Following certification reviews, all providers receive a written certification review report that details the specific areas of non-compliance found during the review and includes instruction regarding the provider's responsibility with regard to the areas of deficiency. The State then conducts follow-up activities in accordance with TxHmL program provider review procedures and consumer directed services agency review procedures to ensure corrective action has been implemented.

- ii. **Remediation Data Aggregation**

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

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

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

c. Timelines

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

- No**
- Yes**

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

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

- Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

- Yes. The State requests that this waiver be considered for Independence Plus designation.**
- No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Participation in the consumer directed services option provides the individual, or the legally authorized representative, the opportunity to be the employer of persons providing waiver services chosen for self-direction. Each individual or legally authorized representative electing the consumer directed services option must receive support from a financial management services provider referred to as a consumer directed service agency, chosen by the individual or legally authorized representative. The individual or the legally authorized representative is the employer and may appoint a designated representative to assist with employer responsibilities. The individual or legally authorized representative may choose to receive support consultation provided by a support advisor.

An individual or the individual's legally authorized representative may choose to direct any service component provided through the waiver as listed in Appendix C except Extended State Plan Services: Prescription Medications.

An alternate service delivery option, the current traditional agency model (provider-managed service delivery) is available to provide authorized services that the individual/legally authorized representative 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 legally authorized representative is the common-law employer of service providers and has decision-making authority over providers of those services. The employer or designated representative, with the assistance and final approval of the consumer directed services agency, budgets authorized funds for those services to be delivered through the consumer directed services option. DADS authorizes the funds for the services allocated for the consumer directed services option on the service plan.

Support consultation is an optional service available to provide assistance and skills training for the individual, legally authorized representative, or designated representative in meeting employer responsibilities and succeeding in the consumer directed services option. When authorized by the individual's service planning team, the individual may receive this service from a support advisor associated with a consumer directed services agency or from a qualified independent support advisor.

The service coordinator informs the individual and legally authorized representative of the option to self-direct available waiver services at the time of enrollment in the waiver and at least annually thereafter. The individual or legally authorized representative may elect at any time to choose the consumer directed services option, terminate participation in the consumer directed services option, or to change consumer directed services agencies.

The consumer directed services option is available statewide to all TxHmL program participants or their legally authorized representatives.

Entities/individuals involved in supporting participants or participants' legally authorized representatives who are directing services and supports include:

- The individual or legally authorized representative, as the employer, may appoint an adult as a designated representative to assist in meeting employer responsibilities to the extent directed by the employer;
- The individual's service coordinator provides information about the consumer directed services 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 consumer directed services option.
- A third-party entity, a consumer directed services agency, chosen by the individual or legally authorized representative, provides financial management services. The consumer directed services agency holds a HHSC/DADS Texas Medicaid provider agreement (contract).
- 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 consumer directed services option, an individual or legally authorized representative must:

- Select a consumer directed services agency;
- Participate in orientation and ongoing training conducted by the consumer directed services agency;
- Perform all employer tasks that are required for self-direction or designate designated representative 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.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

- Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
 - Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
 - Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.
- c. **Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*
- Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
 - Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
 - The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

- d. **Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):
- Waiver is designed to support only individuals who want to direct their services.**
 - The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
 - The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

- e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

A service coordinator employed by the local authority provides the individual and legally authorized representative

with a written and oral explanation of the consumer directed services option initially and at least annually to the individual or the legally authorized representative, and is also provided at any time on request of the individual or the legally authorized representative.

Each individual or legally authorized representative is provided information sufficient to assure informed decision-making and understanding of the consumer directed services option and of the traditional agency-directed (provider-managed) service delivery option. The information includes the responsibilities and choices individuals can make with the election of the consumer directed services option.

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

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

- The State does not provide for the direction of waiver services by a representative.**
- The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: (*check each that applies*):

- Waiver services may be directed by a legal representative of the participant.**
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The waiver participant or the legally authorized representative serving as the employer may appoint a non-legal representative adult as a designated representative to assist in performance of employer responsibilities to the extent desired by the individual or legally authorized representative. The individual/employer documents the employer responsibilities that the designated representative may perform and those that the designated representative may not perform on the individual's/employer's behalf. The individual/employer provides this documentation to the consumer directed services agency. The consumer directed services agency monitors performance of employer responsibilities performed by the individual/employer and, when applicable, the designated representative in accordance with the individual's/employer's documented directions. Neither the designated representative nor the spouse of the designated representative may be employed by, receive compensation from, or be the provider of waiver services for the individual.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

- g. **Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Employment Assistance	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Behavioral Support	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Community Support	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Dietary	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Adaptive Aids	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Dental	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Skilled Nursing	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Minor Home Modifications	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Respite	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Occupational Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Support Consultation Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Supported Employment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Audiology	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Day Habilitation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Speech/Language Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

- h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

Yes. Financial Management Services are furnished through a third party entity. (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

Governmental entities

Private entities

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.
Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

FMS are covered as the waiver service specified in Appendix C1/C3

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

- FMS are provided as an administrative activity.

Provide the following information

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

Private entities furnish financial management services. These entities, called consumer directed services agencies, are procured through an open enrollment process. The State has Medicaid provider agreements with these consumer directed services agencies to provide financial management services to individuals across the state.

Consumer directed services agencies hold HHSC/DADS Texas Medicaid provider agreements. In addition, DADS uses a contract, which includes the requirements of the Medicaid provider agreement, which covers additional state requirements.

Consumer directed services agencies are prohibited from providing case management to an individual who has chosen the consumer directed services option.

- ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

Entities are compensated with a flat monthly fee per individual. Consumer directed services agencies provide financial management services, not administrative activities.

- iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

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

Specify:

Supports furnished when the participant exercises budget authority:

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

Specify:

Additional functions/activities:

- Executes and holds Medicaid provider agreements as authorized under a written agreement

with the Medicaid agency

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

Specify:

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

HHSC delegated to DADS the oversight of the execution of the HHSC/DADS Texas Medicaid provider agreements with consumer directed services agencies. DADS is responsible for the oversight of consumer directed services agencies. Biennially, DADS conducts monitoring reviews of consumer directed services agencies to determine if the consumer directed services agency is in compliance with the provider agreement and with program rules and requirements. These reviews are conducted at the location where the consumer directed service agencies are providing financial management services. Texas monitors 100 percent of the consumer directed services agencies. DADS reports the results of the monitoring to HHSC.

DADS assesses a consumer directed services agency's performance by:

1. Measuring adherence to rules as described in Title 40 of the Texas Administrative Code, Part 1, Chapter 41;
2. Reviewing individual satisfaction with financial management services;
3. Matching payroll, optional benefits and tax deposits to time sheets;
4. Assessing adherence to state and federal tax laws;
5. Ensuring that the hours worked and the rate of pay are consistent with individual budgets;
6. Reviewing administrative payments;
7. Reviewing the provider agreements.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

- j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

- Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Employment Assistance	<input type="checkbox"/>

Behavioral Support	<input type="checkbox"/>
Prescription Medications	<input type="checkbox"/>
Community Support	<input type="checkbox"/>
Dietary	<input type="checkbox"/>
Adaptive Aids	<input type="checkbox"/>
Dental	<input type="checkbox"/>
Skilled Nursing	<input type="checkbox"/>
Minor Home Modifications	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>
Support Consultation Services	<input checked="" type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Audiology	<input type="checkbox"/>
Financial Management Services	<input checked="" type="checkbox"/>
Day Habilitation	<input type="checkbox"/>
Speech/Language Therapy	<input type="checkbox"/>

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (*select one*).

- No. Arrangements have not been made for independent advocacy.**
- Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

- l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

An individual or legally authorized representative may voluntarily terminate participation in the consumer directed services option at any time. The individual's service coordinator assists the individual in revising the service plan for the transition of services previously delivered through the consumer directed services option to be delivered by the TxHmL program provider chosen by the individual or legally authorized representative. The TxHmL program provider assists the individual as necessary to ensure continuity of all waiver services through the traditional agency service delivery option (provider managed service delivery) and maintenance of the individual's health and welfare during the transition from the consumer directed services option. The consumer directed services agency closes the employer's payroll and payable accounts and completes all deposits and filings of required reports with governmental agencies on behalf of the individual.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Involuntary termination of the consumer directed services option may occur when:

- The individual's service planning team, in conjunction with the consumer directed services agency or DADS staff, determines that continued participation in the consumer directed services 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 consumer directed services agency, or DADS staff determines that the individual or the individual's representative, when provided with additional support from the consumer directed services agency 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 consumer directed services option. The consumer directed services agency closes the employer's payroll and payable accounts and completes all deposits and filing of required reports with governmental agencies on behalf of the individual.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

Waiver Year	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
	Number of Participants	Number of Participants
Year 1		277
Year 2		282
Year 3		282

Year 4			282
Year 5			282

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

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

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

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

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

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

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

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

Specify how the costs of such investigations are compensated:

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

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

- Discharge staff (common law employer)**
- Discharge staff from providing services (co-employer)**
- Other**

Specify:

Appendix E: Participant Direction of Services

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

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

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

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

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The service plan is developed in the same manner for the individual who elects the consumer directed services option as it is for the individual who elects to have services delivered through the traditional provider-managed service delivery option. The service plan must be approved by DADS. The consumer-directed budget is the estimated cost of the self-directed services in the approved service plan and the adopted consumer directed services reimbursement rates. The consumer-directed budget is developed by the

individual or legally authorized representative with assistance from the consumer directed services agency.

The consumer-directed budget is allocated to each self-directed service based on the approved service plan. The budget for each service, and any revisions, must be approved by the consumer directed services agency prior to implementation. The consumer directed services agency must ensure that projected expenditures are within the authorized budget for each service, are allowable and reasonable, and are projected over the effective period of the plan to ensure that sufficient funds will be available to the end date of the service plan. With approval of the consumer directed services agency, the individual or legally authorized representative may make revisions to a specific service budget that does not change the amount of funds available for the service based on the approved service plan.

Employer-related costs are paid for using the consumer-directed budget and include costs for equipment, supplies or activities that will provide direct benefit to the individuals who self-direct services to support specific outcomes related to being an employer including: recruiting expenses, fax machine for sending employee time sheets to the consumer directed services agency, criminal conviction history checks from the Texas Department of Public Safety, acquiring other background checks of a potential service provider, purchased employee job-specific training, cardio-pulmonary resuscitation training, first-aid training, and Hepatitis B vaccination if elected by an employee. An individual may use up to a maximum of \$600 of the consumer-directed budget for employer-related support activities.

Support consultation has a specific reimbursement rate and is a component of the individual's service budget. In conjunction with the service planning team, the individual or legally authorized representative determines the level of support consultation necessary for inclusion in the individual's service plan.

Revisions to the budget for a particular service or a request to shift funds from one service to another is a service plan change and must be justified by the service planning team and authorized by the State. With assistance of the consumer directed services agency, the individual or legally authorized representative revises the consumer-directed budget to reflect the revision in the service plan.

Information concerning budget methodology for the consumer-directed budget is contained in rule and available to the public online at the following site:
[http://info.sos.state.tx.us/pls/pub/readtac\\$ext.ViewTAC?tac_view=5&ti=40&pt=1&ch=41&sch=E&rl=Y](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=5&ti=40&pt=1&ch=41&sch=E&rl=Y)

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

- iii. Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The individual or the legally authorized representative participates as a member of the service planning team that develops the individual's person-directed plan upon which the service plan is based. They are apprised of the budget as it is developed. The individual develops the consumer directed services budget based on the finalized service plan and authorized budget.

The consumer directed services agency and the local authority service coordinator inform the individual of the amount authorized for the particular service before the budget is finalized and the total budget once finalized.

The individual may request an adjustment to the budget at any time, subject to the individual cost limit as indicated in Appendix B-2-a of \$17,000.

When DADS denies an individual's request for an adjustment to the budget or reduces the budget, the individual is entitled to a fair hearing. The procedures for a fair hearing are provided in Appendix F, Participant Rights.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

- Modifications to the participant directed budget must be preceded by a change in the service plan.**
- The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

An individual's consumer directed services budget is calculated and monitored based on projected utilization and frequency of the service as determined by the service planning team. The consumer directed services agency is required to monitor payroll every pay period (two weeks) and expenditures (as processed for payment) and report over- and under-utilization to the employer and the service coordinator. When an over- or under-utilization is not corrected by the employer (individual or legally authorized representative), the consumer directed services agency notifies the 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 deviation or revise the service plan.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

At the time of enrollment, at least annually and upon request, the local authority service coordinator shares the individual's rights and responsibilities with the individual or legally authorized representative and obtains the individual's or legally authorized representative's signature acknowledging receipt of the information. These rights include the right to participate in decisions and to be informed of the reasons for decisions regarding plans for enrollment, service termination, transfer, suspension, or denial of services.

If services are reduced, denied, suspended or terminated, an individual is entitled to a fair hearing in accordance with Title 1 of the Texas Administrative Code Part 15, Chapter 357, Subchapter A. DADS sends a letter to the individual or legally authorized representative that outlines the fair hearing procedure. This letter informs the individual of the opportunity to request a fair hearing via the official Notice of Denial or Reduction of Texas Home Living (TxHmL). The notification explains the person's right of appeal, and the right to have others represent the individual, including legal counsel. The local authority service coordinator may provide information to individuals concerning available legal services in the community.

An opportunity for a fair hearing under 42 Code of Federal Regulations, Part 431, Subpart E, will be offered to individuals who are not given the choice of home or community-based services as an alternative to institutional care or who are denied the service(s) of their choice. DADS and the TxHmL provider retain copies of the notice of adverse action taken by the State and the notice to the individual of the opportunity to request a fair hearing. The notice informs an individual or legally authorized representative whether or not the individual is eligible to receive or continue to receive services while the individual's appeal is under consideration and the actions that the individual must take in order for current services to continue. If an individual or legally authorized representative elects to request a fair hearing, DADS and the TxHmL provider retain a copy of the individual's written request for a hearing in the individual's record. Individuals or legally authorized representatives must request a fair hearing within 12 calendar days of the date of the notice. During the fair hearing process, services continue at the level provided prior to denial and until the fair hearing process is complete, if the appeal is filed within 12 calendar days of the notice.

If an individual requests a fair hearing, a representative of DADS completes Form H4800, Petition for Fair Hearing, and sends it to the HHSC hearing officer. The DADS representative must send Form H4800 to the HHSC hearing officer within five calendar days after the date DADS receives the request for appeal.

Form H4803, Acknowledgement and Notice of Fair Hearing, serves as a notice of the hearing. The HHSC hearing officer sends Form H4803 to the appellant and to DADS to acknowledge the request for a hearing and to set a time, date, and place for the hearing. DADS sends a copy of Form H4800-A, A Petition for Fair Hearing Addendum, along with copies of all relevant documentation to all known parties and required witnesses within five calendar days of receipt of Form H4803. The HHSC hearing office files the decision on Form H4809, Update after Fair Hearing (data entry form), in the appeal file. DADS will implement the decision of the HHSC hearing officer within ten calendar days of the date of the decision and send Form H4807 to the HHSC hearing office documenting that the decision has been implemented.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*
- No. This Appendix does not apply**
 - Yes. The State operates an additional dispute resolution process**
- b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

- a. **Operation of Grievance/Complaint System.** *Select one:*
- No. This Appendix does not apply**

- **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**
- b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

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).

To facilitate an efficient consumer response system, DADS has identified the Office of Consumer Rights and Services as its centralized source for the receipt of complaints by individuals, legally authorized representatives, family members, and the general public, as well as concerns and questions regarding the facilities/agencies regulated by DADS, DADS services, programs, or staff. The DADS Office of Consumer Rights and Services ensures that all contacts are handled in a timely, professional manner and are addressed by the proper authorities. All complaints received are acknowledged. DADS staff advises complainants that the formal filing of a complaint is not required, and is not a substitute for the applicant/individual to request a fair hearing if enrollment or services are denied or suspended. The individual's service coordinator also advises the individual or legally authorized representative that filing a complaint is not a pre-requisite or substitute for requesting a fair hearing.

Grievances or complaints can be submitted by telephone by calling a toll-free line, by e-mail, or by written correspondence. In-office employees answer the toll-free line from 8 a.m. to 5 p.m. Monday through Friday. Voice mail is available 24 hours a day, seven days a week. Voice mail messages are monitored between 8 a.m. and 5 p.m., Central time, including weekends and holidays. Complaints may be anonymous. The identity of all complainants and individuals is protected by law. The DADS Office of Consumer Rights and Services investigates the complaint and attempts resolution within ten 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, the agency with statutory responsibility for investigation of such allegations. Resolution of complaints not referred to Department of Family and Protective Services are tracked and recorded in the Office of Consumer Rights and Services complaint database. The status of all complaints unresolved in 90 days are documented in follow-up letters to the complainant unless doing so places the complainant in jeopardy. When Consumer Rights and Services staff determines DADS has no jurisdiction to investigate, complaints are referred to other agencies, boards or entities as required.

Created by the 78th Texas Legislature, the HHSC Office of the Ombudsman assists the public when the DADS normal complaint process cannot, or does not, satisfactorily resolve an issue. The Office of the Ombudsman includes the following services:

- conducting independent reviews of complaints concerning agency policies or practices;
- ensuring that policies and practices are consistent with the goals of HHSC;
- ensuring that individuals are treated fairly, respectfully, and with dignity; and
- making referrals to other agencies as appropriate.

The process to assist with complaints and issues is as follows:

- A member of the public, an individual, or a provider makes first contact with HHSC or with DADS to request assistance with an issue or complaint;
- If not able to resolve the issue or complaint, the Office of the Ombudsman may be contacted;
- The Office of the Ombudsman will provide an impartial review of actions taken by the program or department; and
- The Office of the Ombudsman will seek a resolution and may use mediation if appropriate.

Often it is necessary for the Office of the Ombudsman to refer an issue to another appropriate department. If so, the Office of the Ombudsman will follow up with the complainant to determine if a resolution has been achieved, or to refer the complainant to other available known resources.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The State operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

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

The program provider must report the death of an individual to the local authority 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. If the program provider reasonably believes that the individual's legally authorized representative or family does not know of the individual's death, the program provider notifies the individual's legally authorized representative 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.

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

At the time an individual is enrolled in TxHmL a local authority must assure that an individual and legally authorized representative is informed orally and in writing of the processes for reporting allegations of abuse, neglect or exploitation. The toll free number for the Department of Family and Protective Services must be provided.

A program provider must, at the time an individual is enrolled, ensure that the individual and the legally authorized representative are informed of how to report allegations of abuse, neglect, or exploitation to the Department of Family and Protective Services and are provided with the Department of Family and Protective Services toll-free telephone number in writing.

In addition to information provided to all individuals in the waiver, the consumer directed services agency provides individuals electing the consumer directed services option, the individual's legally authorized representative and, if applicable, the designated representative, training and written information related to reporting allegations of abuse, neglect, or exploitation.

The program providers must ensure the continuous availability of trained and qualified service providers to deliver the required services as determined by the individual's needs. The training is provided as needed.

Evidence supporting compliance with these requirements is reviewed during the State's annual certification reviews of TxHmL program providers who are serving at least one individual, annual contract reviews of local authorities and biennial contract reviews of consumer directed services agencies.

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

The Texas Department of Family and Protective Services receives allegations of abuse, neglect and exploitation 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, the Department of Family and Protective Services investigations must be completed within 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, an individual's program provider must inform the individual, legally authorized representative, and the individual's service coordinator of the findings of the investigation no later than five calendar days from the program provider's receipt of the investigation report and the corrective action taken by the program provider if the Department of Family and Protective Services confirms that abuse, neglect, and exploitation occurred.

The program provider must inform the individual and legally authorized representatives of the process to appeal the investigation finding, and the process for requesting a copy of the investigative report.

Additionally, DADS Consumer Rights and Services will conduct an investigation of all complaints received, other than those for abuse, neglect and exploitation. Within ten days of the complaint, Consumer Rights and Services will document their findings. Any unresolved complaints will be forwarded to the appropriate department for additional follow-up.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Department of Family and Protective Services 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 the Department of Family and Protective Services. 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 abuse, neglect and exploitation 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 initial and annual certification reviews and some onsite visits, DADS staff compiles data related to all critical incidents reported by or involving the program provider. The information may be used during certification reviews or onsite visits in determining 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.

Unresolved issues that Consumer Rights and Services forwards to Waiver Survey and Certification will result in a review of any evidence submitted pertaining to the issue. Steps to resolve issues will be taken immediately, if necessary, or up to seven days from the time Waiver Survey and Certification receives the referral from Consumer Rights and Services. Action taken for follow-up will include a desk review of the available evidence, the request for additional evidence and/or an on-site visit to further investigate the issue. Findings related to the issues are documented in the Waiver Survey and Certification database and shared with Consumer Rights and Services.

Oversight activities occur on an ongoing basis. Information regarding confirmed instances of abuse, neglect or exploitation are monitored, tracked and trended for purposes of training the provider base to reduce the risk of recurrence.

DADS annually aggregates the data and reports to HHSC. HHSC discusses with DADS any significant findings and together with DADS prepares a remediation plan or improvement plan as needed.

Appendix G: Participant Safeguards

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

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

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

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

- The use of restraints or seclusion is permitted during the course of the delivery of waiver services.**

Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State allows the use of personal restraints, drugs used as restraints and mechanical restraints. The State prohibits the use of seclusion. The following safeguards apply to all restraints used.

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 the restraint to the individual's service coordinator so that any necessary changes may be made to the individual's service plan. If restrictive or intrusive techniques, including restraint, are used as part of a behavioral support plan, and the program provider must assure that the implementation of such techniques includes:

- (1) Approval by the individual's service planning team, which includes the service coordinator.
- (2) Written consent of the individual or legally authorized representative;
- (3) Verbal and written notification to the individual or legally authorized representative of the right to discontinue participation in the behavioral support plan at any time;
- (4) Assessment of the individual's needs and current level/severity of the behavior(s) targeted by the plan;
- (5) Use of techniques appropriate to the level/severity of the behavior(s) targeted by the plan;
- (6) A written behavior support plan developed by a psychologist or behavior analyst with input from the individual, legally authorized representative, the individual's service planning team, and other professional personnel;
- (7) Collection and monitoring of behavioral data concerning the targeted behavior(s);
- (8) Allowance for the decrease in the use of intervention techniques based on behavioral data;
- (9) Allowance for revision of the behavioral support plan when desired behavior(s) are not displayed or techniques are not effective;
- (10) Consideration of the effects of the techniques in relation to the individual's physical and psychological well-being; and
- (11) At least annual review by the individual or legally authorized representative, local authority service coordinator and TxHmL program provider to determine the effectiveness of the program and the need to continue the techniques.

The program certification principles also require provider personnel to report allegations of abuse, neglect, or exploitation within one hour.

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.

At least annual on-site certification reviews conducted by DADS evaluate program provider's

compliance with these principles.

Complaints concerning unnecessary/unapproved use of restraint can be made to the local authority, DADS, or the Department of Family and Protective Services. The service coordinator must assure that an individual or legally authorized representative is informed orally and in writing of the processes for filing complaints about the provision of TxHmL program services including:

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

Restraints are reviewed as a result of a certification review and/or as a follow-up to a complaint from Consumer Rights and Services. During a review of the TxHmL provider, critical incident data is obtained from restraint data from the State database system, incident reports/service records from the program provider or interviews from consumers, legally authorized representatives, staff and other informants.

- 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 the Department of Family and Protective Services investigative findings.

Deficiencies related to misuse of restraint or seclusion observed during on-site provider reviews are entered into the DADS Client Assignment and Registration 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.

Annually, DADS reports aggregate data to HHSC on critical incidents including use of restraints, serious injuries and deaths. TxHmL providers also enter the number of participants with a behavior intervention program. HHSC discusses with DADS any significant findings and together with DADS prepares a remediation plan or improvement plan as needed.

DADS and HHSC review the data for trends and patterns. Improvement strategies are developed and implemented to reverse adverse trends and address patterns of concern.

Appendix G: Participant Safeguards

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

- b. **Use of Restrictive Interventions.** (*Select one*):

- The State does not permit or prohibits the use of restrictive interventions**

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

- The use of restrictive interventions is permitted during the course of the delivery of waiver services**

Complete Items G-2-b-i and G-2-b-ii.

- i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including

restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

When a behavioral support plan includes techniques that involve restriction of individual rights or intrusive techniques, including restraints, the program provider must assure that the implementation of such techniques includes:

- (A) Approval by the individual's service planning team;
- (B) Written consent of the individual or legally authorized representative;
- (C) Verbal and written notification to the individual or legally authorized representative 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 legally authorized representative, 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.

A restraint may be used in a behavioral emergency, as part of a behavioral support plan to address inappropriate behavior exhibited voluntarily by an individual, during a medical or dental procedure to protect the individual or others, to protect the individual from involuntary self injury, or to provide postural support in obtaining and maintaining normative bodily functioning. The TxHmL program provider must ensure the continuous availability of trained and qualified service providers to deliver the required services as determined by the individual's needs.

Complaints concerning unnecessary/unapproved restriction of rights can be made to the local authority, DADS, or the Department of Family and Protective Services. The local authority must assure that an individual or legally authorized representative is informed orally and in writing of the processes for filing complaints about the provision of TxHmL program services including:

The telephone number of the local authority 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 the Department of Family and Protective Services to file a complaint of abuse, neglect, or exploitation.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

DADS 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 the Department of Family and Protective Services investigative findings.

DADS annually aggregates the data and reports to HHSC. HHSC discusses with DADS any significant findings and together with DADS prepares a remediation plan or improvement plan as needed.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- No. This Appendix is not applicable** (*do not complete the remaining items*)
 Yes. This Appendix applies (*complete the remaining items*)

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

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

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

- Not applicable.** (*do not complete the remaining items*)
 Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. (*complete the remaining items*)

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the State:

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

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

i. Performance Measures

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

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

Performance Measure:

G.a.1 Number and percent of participants who were informed of procedures for filing a complaint. N: # of participants reviewed who were informed of procedures for filing a complaint, D: # of participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System and Records Review, on-site

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

Data Aggregation and Analysis:

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

Performance Measure:

G.a.2 Number and percent of participants who were informed of the procedure for

reporting allegations of abuse, neglect, and exploitation. N: # of participants reporting they received information about reporting abuse, neglect, and exploitation, D: # of participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System and Records review, on-site.

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

Data Aggregation and Analysis:

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

	Specify:
--	----------

Performance Measure:

G.a.3 Number and percent of participants who did not have confirmed instance of abuse, neglect, and exploitation. N: # of participants who did not have a confirmed instance of abuse, neglect, and exploitation, D: # of enrolled participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System and Quality Assurance and Improvement DataMart

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

Data Aggregation and Analysis:

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

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

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

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

- licensed intermediate care facility;
- nursing facilities;
- assisted living facilities;
- adult foster care facilities;
- adult day care facilities;
- home and community support services agencies, which include hospice and home health agencies; and
- persons exempt from licensing under the Health and Safety Code, §142.003(a)(19), which include Home and Community-based Services Program providers.

In addition, in accordance with federal law, the State maintains a Nurse Aide Registry that lists certified nurse aides. The Nurse Aide Registry indicates if an aide has been confirmed to have abused, neglected, or exploited a resident of a licensed nursing facility. Program providers and local authorities must consult these registries prior to offering employment to a non-licensed service provider and refrain from employing that person if either registry indicated the person was confirmed to have abused, neglected, or exploited an individual receiving services.

Texas state law prohibits program providers and local authorities from employing a person whose criminal background indicates the person has been convicted of certain felonies. Program providers and local authorities 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.

The Quality Assurance and Improvement unit of DADS will continue its National Core Indicators survey project with the individuals who participate in home and community-based service programs operated by the State. Individuals receiving TxHmL are included in the sample at least every three years. As a part of the National Core Indicators survey, individuals who receive services in the TxHmL program may respond to indicators regarding health, welfare and rights. Some of the topics in the survey tool include safety from abuse and neglect, the ability to secure needed health services, medication management, protection of and respect for individual rights, and support to maintain health habits. Discovery findings from the National Core Indicators survey project will be routinely evaluated to assess the status of remediation and improvement activities. In addition, the State will use findings to update the TxHmL Quality Improvement Strategy as necessary. Findings from the National Core Indicators survey will be provided to HHSC each year the survey is administered.

b. Methods for Remediation/Fixing Individual Problems

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

When DADS detects provider non-compliance with the program certification principles the agency requires the provider to implement corrective action. Following certification reviews, all providers receive a written certification review report that details the specific areas of non-compliance found during the review and includes instruction regarding the provider’s responsibility with regard to the areas of deficiency. The State

then conducts follow-up activities in accordance with TxHmL program provider review procedures. When appropriate a referral will be made to the Department of Family and Protective Services.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- No**
- Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care

services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State’s Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The quality oversight plan utilizes numerous quality indicators that are tracked and reported on a quarterly basis. The TxHmL system data is aggregated on no less than an annual basis. The State analyzes trends and identifies and prioritizes areas for improvement. These findings are reported to the Quality Review Team.

The Quality Review Team, which consists of representatives from several departments within DADS and the State Medicaid Agency, reviews TxHmL data to establish priorities and directs the improvement activities for the waiver. The Quality Review Team oversees implementation of the quality oversight plan and related processes. This includes making recommendations for new or revised quality measures, identifying and facilitating access to new data sources, identifying new intra- and interagency processes impacting any and all phases of the quality program, and other actions needed to assure continued improvement of TxHmL waiver program.

- ii. System Improvement Activities

Responsible Party (check each that applies):	Frequency of Monitoring and Analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Other Specify:

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State’s targeted standards for systems improvement.

The Quality Review Team meets quarterly and reviews comprehensive quality reports from each waiver program at least annually. These reports are generated from the DADS Quality Assurance and Improvement Data Mart that includes data on all of the waiver’s quality improvement strategy measures. These reports also include remediation activities and outcomes. HHSC and DADS staff present the reports and recommendations for system improvements to the Quality Review Team. Priorities are established by the Quality Review Team.

Improvement plans are developed as issues are identified and the Quality Review Team reviews, modifies, if needed, and approves all improvement plans. All active improvement plans for all waivers are monitored at each Quality Review Team meeting. This includes updates to determine whether or not improvement activities have had the intended effect. The Quality Assurance and Improvement Data Mart produces standardized reports and provides capability for ad-hoc reporting. The areas covered by the reports include, at minimum: waiver administration and operation, participant access and eligibility, participant services, participant-centered planning and service delivery, participant safeguards, and financial accountability. This system has the capability to provide management reports at the individual level or any level of aggregation needed.

To facilitate communication with external stakeholders, the agency has implemented Texas Quality Matters, which is a web-based medium that provides external stakeholders with an increased ability to access quality reporting information. Texas Quality Matters provides the State with the ability to conduct online surveys related to quality improvement.

Stakeholders have the opportunity to provide testimony on policies and rules governing the delivery of services in the TxHmL program in writing and at meetings of the Medical Care Advisory Committee, the DADS Advisory Council, and the HHSC Advisory Council.

The Promoting Independence Advisory Committee is comprised of member representatives from all departments of the State Medicaid Agency and external stakeholders. The Promoting Independence Advisory Council, Texas’s Olmstead implementation committee, studies and makes recommendations to the State regarding appropriate care settings for persons with disabilities. The Promoting Independence Advisory Council is another venue stakeholders can use to provide input and feedback about the TxHmL waiver program.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

HHSC and DADS will evaluate the Quality Oversight Plan at least every three years. State staff will evaluate the processes and indicators of the quality oversight plan. HHSC and DADS will examine issues such as whether or not the indicators are providing substantive information about each subassuranc; whether the Quality Review Team can be made more effective through changes to its composition or meeting framework; and whether the processes for involving external stakeholders can be improved. Where improvement is needed, staff will make recommendations for changes to the Quality Review Team, and the Quality Review Team will approve or revise recommended changes.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DADS uses a fiscal monitoring process, billing and payment reviews, to ensure that Texas Home Living program providers and consumer directed services agencies 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 consumer directed services agencies 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/consumer directed services agencies service delivery records with its billing records to verify that payments DADS made to the provider or consumer directed services agencies 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 State has mechanisms in place for the return to CMS of any federal matching funds received for improper billing.

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.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

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

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

Performance Measure:

I.a.1 Number and percent of dollars paid in accordance with the reimbursement methodology specified in the approved waiver. N: Sum of dollars paid in accordance with the reimbursement methodology specified in the approved waiver, D: Sum of dollars paid.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Client Assignment and Registration System and Quality Assurance and Improvement DataMart

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

Data Aggregation and Analysis:

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

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

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Program providers enter billing claims into the Client Assignment and Registration System, which assigns the correct reimbursement rate associated with the billing code entered by a program provider. The Client Assignment and Registration System automatically rejects any claim that is entered with an unauthorized billing code or for a service not included in an individual’s authorized service plan. A report on this assurance will be prepared annually and reviewed by the Quality Review Team.

b. Methods for Remediation/Fixing Individual Problems

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

When the State detects provider non-compliance with the program billing guidelines, the agency requires the provider to implement corrective action. Following billing and payment reviews, all providers receive a written review report that details the specific areas of non-compliance found during the review and includes instruction regarding the provider’s responsibility with regard to the areas of deficiency. The State then conducts follow-up activities in accordance with TxHmL program provider review procedures and consumer directed services agency review procedures to ensure corrective action has been implemented. The State recoups funds when claims for services to individuals were found in error.

- ii. **Remediation Data Aggregation**

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

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

c. Timelines

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

operational.

No

Yes

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

HHSC, the State Medicaid agency, determines payment rates every two years. Payment rates are determined for each service, and the rates for services are prospective and uniform statewide. HHSC determines payment rates after analysis of financial and statistical information, and the effect of the payment rates on achievement of program objectives, including economic conditions and budgetary considerations. Information about adopted payment rates is available on the HHSC webpage at <http://www.hhsc.state.tx.us/medicaid/programs/rad/index.shtml>.

All providers are required to submit annual cost reports to HHSC. Providers are responsible for eliminating all unallowable expenses from the cost report prior to submission. The annual cost report contains information on direct service costs, including direct service wages, benefits, contract services and staffing information; facility costs; operations costs; and administrations costs of the providers. The HHSC Office of Inspector General conducts reviews of all cost reports and a sample of cost reports is reviewed on-site. The Office of Inspector General removes any unallowable costs and corrects any errors detected on the cost report in the course of the review or on-site audit. Some cost reports are returned for correction and the revised cost reports are reviewed to determine if appropriate changes are made. Audited cost reports are used in the determination of statewide prospective rates.

Costs reported on the cost reports are projected to the applicable rate period. HHSC determines reasonable methods for projecting each provider's costs to allow for significant changes in cost-related conditions anticipated as occurring between the historical cost reporting period and the prospective rate period.

HHSC uses the projected costs from cost reports to rebase modeled rates for the following services: day habilitation, respite, and community support services. The initial model-based rates for these services were determined using cost, financial, statistical and operational information collected during site visits performed by an independent consultant. The data was collected from cost reports and the service providers' accounting systems. Additionally, the state fiscal year 1996 state wage data, the state fiscal year 1994 cost data and the state fiscal year 1995 data from service providers was reviewed and analyzed. The base model rate year was calendar year 1997.

Skilled nursing, speech and language pathology, audiology, occupational therapy, physical therapy, dietary, behavioral support, employment assistance and supported employment services are provided under more than one Home and Community-Based 1915(c) waiver. The rates for these services are determined by combining the allowable costs per unit of service for the contracted providers in all the waivers offering these services into an array. The array is weighted by the number of units of service and the median cost per unit of service is calculated.

Prescribed medications are paid at cost.

When historical costs are unavailable, such as in the case of changes in program requirements, payment rates may be based on a pro forma approach. This approach involves using historical costs of delivering similar services, where appropriate data are available, and determining the types and costs of products and services necessary to deliver services meeting federal and state requirements. HHSC models rates as specified below.

Minor home modifications, adaptive aids, and dental services are paid at cost. Providers are given additional

payments for the cost of acquiring minor home modifications, adaptive aids, and dental services for consumers; these payments are called requisition fees. The rates for the requisition fees are determined by modeling the estimated time required for staff to conduct the assessment of the need for the service, purchase the item, and complete any necessary follow-up.

In setting the rates for financial management services provided under the consumer directed services option, the reimbursement rate to the financial management services provider is a flat monthly fee, determined by modeling the estimated cost to carry out the financial management responsibilities of the financial management services provider. The payment rate available for the individual's budget for the self-directed service is modeled based on the payment rate to the traditional agency less an adjustment for the traditional agency's indirect costs.

The rate for support consultation is determined by modeling the estimated salary for a person with similar skills and training requirements. This rate is updated periodically for inflation.

TxHmL providers have the option of participating in the attendant compensation rate enhancement for the following services: day habilitation, respite, supported employment, community support services, and employment assistance. HHSC adopted rules at Title 1, Texas Administrative Code §355.112 to establish procedures for providers to obtain additional funds for increased attendant wages, benefits/insurance, and mileage reimbursement. As per these rules, providers who choose to participate in the attendant compensation rate enhancement and receive additional funds must demonstrate compliance with enhanced spending requirements. For providers who choose not to participate in the enhancement program, the attendant compensation rate component will remain constant over time, except for adjustments necessitated by increases in the federal minimum wage.

Participation in the attendant compensation rate enhancement is voluntary. Providers may choose to participate in the attendant compensation rate enhancement by submitting to HHSC a signed Enrollment Contract Amendment choosing to enroll and indicating the level of enhanced add-on rate they desire to receive. Requested add-on rate levels are granted beginning with the lowest level and granting successive levels until requested enhancements are granted within available funds.

Enrollment in the attendant compensation rate enhancement is held in July, prior to the rate year. Funding for the enhancement add-on rate levels is limited by appropriations.

Providers participating in the attendant compensation rate enhancement agree to spend approximately 90 percent of their total attendant revenues, including their enhanced add-on rate revenues, on attendant compensation. Attendant compensation includes salaries, payroll taxes, benefits, and mileage reimbursement. Participating providers must submit reports to HHSC documenting their spending on attendant compensation.

Determination of each provider's compliance with the attendant compensation spending requirement will be made on an annual basis from the cost reports submitted to HHSC. Participants failing to meet their spending requirement for the reporting period will have their enhanced add-on revenues associated with the unmet spending requirements recouped. At no time will a participating provider's attendant care rate after their spending recoupment be less than the rate paid to providers not participating in receiving the enhanced add-on rates. The federal portion of any recouped funds is returned to the federal government.

HHSC holds a public hearing before it approves rates. The purpose of the hearing is to give interested parties an opportunity to comment on the proposed rates. Notice of the hearing is provided to the public via the Texas Register and the HHSC website. The notice of the public hearing includes information about the proposed rate changes and identifies the name, address, and telephone number of the staff member to contact for the materials pertinent to the proposed rates. At least ten working days before the public hearing takes place, material pertinent to the proposed statewide uniform rates is made available to the public. The public may present comments at the hearing or submit written comments regarding the proposed rates.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

TxHmL program providers and consumer directed services agencies submit billing claims directly to DADS.

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

directed services agencies submit electronic claims for the adaptive aids, minor home modifications, or dental treatment.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

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

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)

- Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

TxHmL program providers and consumer directed services agencies 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 no later than 12 months after the last day of the month in which the service component was provided.

TxHmL program providers and consumer directed services agencies submit appropriate receipts for adaptive aids,

minor home modifications, and dental treatment that are authorized for payment by DADS staff. Following authorization, the provider agencies and consumer directed services agencies 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 consumer directed services agencies 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.

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. **Method of payments -- MMIS** (*select one*):

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

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.

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

- d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the

services that the State or local government providers furnish: *Complete item I-3-e.*

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, established in accordance with Chapter 391 of the Texas Local Government Code, which have all been designated by DADS as local authorities.

Local authorities contract as TxHmL program providers, and, therefore, must provide all TxHmL services and receive payment for services provided. Local authorities may also contract to provide financial management services under the consumer directed services option.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

1915(c) WAIVER (01/11)

g. Additional Payment Arrangements

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

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

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

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

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

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
 Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

The non-federal share 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 IGTs or CPEs. The non-federal share is exclusively from state general revenue appropriations.

- 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.

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.

- Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

- b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

- Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.
 Applicable
Check each that applies:
 Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid

Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

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

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

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Payment of the cost for room and board is the responsibility of the participant except when room and board are provided under the waiver as part of out-of-home respite service.

Appendix I: Financial Accountability

1-7: PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

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

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
 - i. Co-Pay Arrangement.**

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

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

ii. **Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. **Co-Payment Requirements.**

iii. **Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. **Co-Payment Requirements.**

iv. **Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

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

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

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

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the

Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/MR

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	8341.10	5142.31	13483.41	88310.49	2724.30	91034.79	77551.38
2	8446.96	5347.97	13794.93	90518.25	2833.27	93351.52	79556.59
3	8630.03	5561.83	14191.86	92781.21	2946.60	95727.81	81535.95
4	8817.29	5784.36	14601.65	95100.74	3064.46	98165.20	83563.55
5	9009.64	6015.78	15025.42	97478.26	3187.04	100665.30	85639.88

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/MR
Year 1	6026	6026
Year 2	6026	6026
Year 3	6026	6026
Year 4	6026	6026
Year 5	6026	6026

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

For average length of stay, no growth in the average monthly service level of 5,738 is assumed. Historical data from the Client Assignment and Registration System is used to calculate an average turnover rate of 24 participants per month or 288 participants per year. Combined, this brings the annual unduplicated participant count to 6,026 for each of the five years.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

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

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

these estimates is as follows:

The Factor D estimates are based upon service utilization data reported in the CMS 372 report for waiver year March 2009-February 2010. For renewal Waiver Year 1, the currently published rates, which are in effect for the period September 2011-August 2013 were used. For renewal year two (March 2013-February 2014), Texas assumed a one percent rate increase. For renewal years three through five, assumed a two percent annual rate increase.

For those services where Texas does not pay a set rate (adaptive aids, dental, and minor home modifications), an annual inflation rate of two percent was assumed for all five years. For more than three prescriptions, an annual inflation rate of four percent was assumed for all five years.

- 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 were based upon the average monthly cost per the CMS 372 report for the Texas Home Living waiver for waiver year March 2009-February 2010, adjusted for differences in length-of-stay, and inflated by 2.6 percent for Waiver Year 5 (March 2010 - February 2011). An annual inflation rate of 2.2 percent was assumed for renewal Waiver Year 1 (March 2011-February 2012), and four percent annually for renewal Waiver Years 2 through 5.

- 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 were based upon the G cost as reported in the claims payment information provided by the Texas Medicaid and Healthcare Partnership which was used to prepare the CMS 372 lag report for waiver 374 (TxHmL program, intermediate care facility) for waiver year September 2008-August 2009, and using a 2.5 percent annual inflator.

- 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 were based upon the G cost as reported in the claims payment information provided by the Texas Medicaid and Healthcare Partnership which was used to prepare the CMS 372 lag report for waiver 374 (TxHmL program, intermediate care facility) for waiver year September 2008-August 2009, and using a 4 percent annual inflator.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	
Day Habilitation	
Respite	
Supported Employment	
Prescription Medications	
Financial Management Services	
Support Consultation Services	
Adaptive Aids	
Audiology	
Behavioral Support	
Community Support	
Dental	
Dietary	

Employment Assistance
Minor Home Modifications
Occupational Therapy
Physical Therapy
Skilled Nursing
Speech/Language Therapy

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						13706439.12
Day Habilitation	Daily	3322	146.00	28.26	13706439.12	
Respite Total:						14157553.60
Respite	Hourly	2413	304.00	19.30	14157553.60	
Supported Employment Total:						383917.05
Supported Employment	Hourly	251	45.00	33.99	383917.05	
Prescription Medications Total:						4160987.25
Prescription Medications	Per Rx	1603	15.00	173.05	4160987.25	
Financial Management Services Total:						758712.00
Financial Management	Monthly	313	12.00	202.00	758712.00	
Support Consultation Services Total:						3319.92
Support Consultation Services	Hourly	9	24.00	15.37	3319.92	
Adaptive Aids Total:						84586.18
Adaptive Aids	Per Item	161	2.00	262.69	84586.18	
Audiology Total:						421.84
Audiology	Hourly	4	2.00	52.73	421.84	
Behavioral Support Total:						66805.20
Behavioral Support	Hourly	210	4.00	79.53	66805.20	

Community Support Total:						15137460.36
Community Support	Hourly	4378	114.00	30.33	15137460.36	
Dental Total:						1372396.26
Dental	Per Visit	2973	2.00	230.81	1372396.26	
Dietary Total:						6412.48
Dietary	Hourly	58	2.00	55.28	6412.48	
Employment Assistance Total:						82629.69
Employment Assistance	Hourly	143	17.00	33.99	82629.69	
Minor Home Modifications Total:						105197.94
Minor Home Modifications	Per Item	27	1.00	3896.22	105197.94	
Occupational Therapy Total:						4522.90
Occupational Therapy	Hourly	31	2.00	72.95	4522.90	
Physical Therapy Total:						10453.05
Physical Therapy	Hourly	27	5.00	77.43	10453.05	
Skilled Nursing Total:						104920.86
Skilled Nursing	Hourly	1419	2.00	36.97	104920.86	
Speech/Language Therapy Total:						116723.70
Speech/Language Therapy	Hourly	90	17.00	76.29	116723.70	
GRAND TOTAL:						50263459.40
Total Estimated Unduplicated Participants:						6026
Factor D (Divide total by number of participants):						8341.10
Average Length of Stay on the Waiver:						348

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						13842242.48
Day Habilitation	Daily	3322	146.00	28.54	13842242.48	

Respite Total:						14296928.48
Respite	Hourly	2413	304.00	19.49	14296928.48	
Supported Employment Total:						387757.35
Supported Employment	Hourly	251	45.00	34.33	387757.35	
Prescription Medications Total:						4327378.65
Prescription Medications	Per Rx	1603	15.00	179.97	4327378.65	
Financial Management Services Total:						766299.12
Financial Management	Monthly	313	12.00	204.02	766299.12	
Support Consultation Services Total:						3352.32
Support Consultation Services	Hourly	9	24.00	15.52	3352.32	
Adaptive Aids Total:						86276.68
Adaptive Aids	Per Item	161	2.00	267.94	86276.68	
Audiology Total:						426.08
Audiology	Hourly	4	2.00	53.26	426.08	
Behavioral Support Total:						67477.20
Behavioral Support	Hourly	210	4.00	80.33	67477.20	
Community Support Total:						15287187.96
Community Support	Hourly	4378	114.00	30.63	15287187.96	
Dental Total:						1399866.78
Dental	Per Visit	2973	2.00	235.43	1399866.78	
Dietary Total:						6476.28
Dietary	Hourly	58	2.00	55.83	6476.28	
Employment Assistance Total:						83456.23
Employment Assistance	Hourly	143	17.00	34.33	83456.23	
Minor Home Modifications Total:						107301.78
Minor Home Modifications	Per Item	27	1.00	3974.14	107301.78	
Occupational Therapy Total:						4568.16
Occupational Therapy	Hourly	31	2.00	73.68	4568.16	
Physical Therapy Total:						10557.00
Physical Therapy	Hourly	27	5.00	78.20	10557.00	
Skilled Nursing Total:						105970.92

Skilled Nursing	Hourly	1419	2.00	37.34	105970.92	
Speech/Language Therapy Total:						117886.50
Speech/Language Therapy	Hourly	90	17.00	77.05	117886.50	
GRAND TOTAL:						50901409.97
Total Estimated Unduplicated Participants:						6026
Factor D (Divide total by number of participants):						8446.96
Average Length of Stay on the Waiver:						348

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						14118699.32
Day Habilitation	Daily	3322	146.00	29.11	14118699.32	
Respite Total:						14583013.76
Respite	Hourly	2413	304.00	19.88	14583013.76	
Supported Employment Total:						395550.90
Supported Employment	Hourly	251	45.00	35.02	395550.90	
Prescription Medications Total:						4500502.65
Prescription Medications	Per Rx	1603	15.00	187.17	4500502.65	
Financial Management Services Total:						781623.60
Financial Management	Monthly	313	12.00	208.10	781623.60	
Support Consultation Services Total:						3419.28
Support Consultation Services	Hourly	9	24.00	15.83	3419.28	
Adaptive Aids Total:						88002.60
Adaptive Aids	Per Item	161	2.00	273.30	88002.60	
Audiology Total:						434.64
Audiology	Hourly	4	2.00	54.33	434.64	
Behavioral Support Total:						68829.60

Behavioral Support	Hourly	210	4.00	81.94	68829.60	
Community Support Total:						15591634.08
Community Support	Hourly	4378	114.00	31.24	15591634.08	
Dental Total:						1427872.44
Dental	Per Visit	2973	2.00	240.14	1427872.44	
Dietary Total:						6606.20
Dietary	Hourly	58	2.00	56.95	6606.20	
Employment Assistance Total:						85133.62
Employment Assistance	Hourly	143	17.00	35.02	85133.62	
Minor Home Modifications Total:						109447.74
Minor Home Modifications	Per Item	27	1.00	4053.62	109447.74	
Occupational Therapy Total:						4659.30
Occupational Therapy	Hourly	31	2.00	75.15	4659.30	
Physical Therapy Total:						10767.60
Physical Therapy	Hourly	27	5.00	79.76	10767.60	
Skilled Nursing Total:						108099.42
Skilled Nursing	Hourly	1419	2.00	38.09	108099.42	
Speech/Language Therapy Total:						120242.70
Speech/Language Therapy	Hourly	90	17.00	78.59	120242.70	
GRAND TOTAL:					52004539.45	
Total Estimated Unduplicated Participants:					6026	
Factor D (Divide total by number of participants):					8630.03	
Average Length of Stay on the Waiver:					348	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						14400006.28

Day Habilitation	Daily	3322	146.00	29.69	14400006.28	
Respite Total:						14876434.56
Respite	Hourly	2413	304.00	20.28	14876434.56	
Supported Employment Total:						403457.40
Supported Employment	Hourly	251	45.00	35.72	403457.40	
Prescription Medications Total:						4680599.70
Prescription Medications	Per Rx	1603	15.00	194.66	4680599.70	
Financial Management Services Total:						797248.56
Financial Management	Monthly	313	12.00	212.26	797248.56	
Support Consultation Services Total:						3488.40
Support Consultation Services	Hourly	9	24.00	16.15	3488.40	
Adaptive Aids Total:						89763.94
Adaptive Aids	Per Item	161	2.00	278.77	89763.94	
Audiology Total:						443.36
Audiology	Hourly	4	2.00	55.42	443.36	
Behavioral Support Total:						70207.20
Behavioral Support	Hourly	210	4.00	83.58	70207.20	
Community Support Total:						15901071.12
Community Support	Hourly	4378	114.00	31.86	15901071.12	
Dental Total:						1456413.24
Dental	Per Visit	2973	2.00	244.94	1456413.24	
Dietary Total:						6738.44
Dietary	Hourly	58	2.00	58.09	6738.44	
Employment Assistance Total:						86835.32
Employment Assistance	Hourly	143	17.00	35.72	86835.32	
Minor Home Modifications Total:						111636.63
Minor Home Modifications	Per Item	27	1.00	4134.69	111636.63	
Occupational Therapy Total:						4752.30
Occupational Therapy	Hourly	31	2.00	76.65	4752.30	
Physical Therapy Total:						10983.60
Physical Therapy	Hourly	27	5.00	81.36	10983.60	

Skilled Nursing Total:						110256.30
Skilled Nursing	Hourly	1419	2.00	38.85	110256.30	
Speech/Language Therapy Total:						122644.80
Speech/Language Therapy	Hourly	90	17.00	80.16	122644.80	
GRAND TOTAL:						53132981.15
Total Estimated Unduplicated Participants:						6026
Factor D (Divide total by number of participants):						8817.29
Average Length of Stay on the Waiver:						348

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						14686163.36
Day Habilitation	Daily	3322	146.00	30.28	14686163.36	
Respite Total:						15177190.88
Respite	Hourly	2413	304.00	20.69	15177190.88	
Supported Employment Total:						411476.85
Supported Employment	Hourly	251	45.00	36.43	411476.85	
Prescription Medications Total:						4867910.25
Prescription Medications	Per Rx	1603	15.00	202.45	4867910.25	
Financial Management Services Total:						813211.56
Financial Management	Monthly	313	12.00	216.51	813211.56	
Support Consultation Services Total:						3557.52
Support Consultation Services	Hourly	9	24.00	16.47	3557.52	
Adaptive Aids Total:						91560.70
Adaptive Aids	Per Item	161	2.00	284.35	91560.70	
Audiology Total:						452.24
Audiology	Hourly	4	2.00	56.53	452.24	

Behavioral Support Total:						71610.00
Behavioral Support	Hourly	210	4.00	85.25	71610.00	
Community Support Total:						16220490.00
Community Support	Hourly	4378	114.00	32.50	16220490.00	
Dental Total:						1485548.64
Dental	Per Visit	2973	2.00	249.84	1485548.64	
Dietary Total:						6873.00
Dietary	Hourly	58	2.00	59.25	6873.00	
Employment Assistance Total:						88561.33
Employment Assistance	Hourly	143	17.00	36.43	88561.33	
Minor Home Modifications Total:						113869.26
Minor Home Modifications	Per Item	27	1.00	4217.38	113869.26	
Occupational Therapy Total:						4847.16
Occupational Therapy	Hourly	31	2.00	78.18	4847.16	
Physical Therapy Total:						11203.65
Physical Therapy	Hourly	27	5.00	82.99	11203.65	
Skilled Nursing Total:						112469.94
Skilled Nursing	Hourly	1419	2.00	39.63	112469.94	
Speech/Language Therapy Total:						125092.80
Speech/Language Therapy	Hourly	90	17.00	81.76	125092.80	
GRAND TOTAL:						54292089.14
Total Estimated Unduplicated Participants:						6026
Factor D (Divide total by number of participants):						9009.64
Average Length of Stay on the Waiver:						348