

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 waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Request Information

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

B. Program Title:

Youth Empowerment Services (YES)

C. Waiver Number: TX.0657

D. Amendment Number:

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

02/01/21

Approved Effective Date of Waiver being Amended: 04/01/18

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

This amendment request proposes to amend:

- Appendix I to add a requirement for YES program providers to use electronic visit verification for in-home respite. This requirement is being included to comply with §1903(l) of the Social Security Act, as added by the 21st Century Cures Act.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
Waiver Application	Main
Appendix A Waiver Administration and Operation	

Component of the Approved Waiver	Subsection(s)
Appendix B Participant Access and Eligibility	<input type="text"/>
Appendix C Participant Services	<input type="text"/>
Appendix D Participant Centered Service Planning and Delivery	<input type="text"/>
Appendix E Participant Direction of Services	<input type="text"/>
Appendix F Participant Rights	<input type="text"/>
Appendix G Participant Safeguards	<input type="text"/>
Appendix H	<input type="text"/>
Appendix I Financial Accountability	I-1
Appendix J Cost-Neutrality Demonstration	<input type="text"/>

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

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

Appendix I-1 will be amended to require YES program providers to use electronic visit verification for in-home respite. This requirement is being included to comply with §1903(l) of the Social Security Act, as added by the 21st Century Cures Act.

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):

Youth Empowerment Services (YES)

C. Type of Request: amendment

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

3 years 5 years

Draft ID: TX.017.02.02

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 04/01/18

Approved Effective Date of Waiver being Amended: 04/01/18

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 Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)

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

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.

HHSC was authorized by the Texas Legislature to develop and implement a plan to prevent custody relinquishment of youth with serious emotional disturbances (SED). To this end, HHSC was authorized to seek any necessary waivers or authorizations from the federal government. After review of various options, HHSC and DSHS, in collaboration with stakeholders, decided to request Youth Empowerment Services (YES) 1915(c) Medicaid waiver to improve access to services and allow more flexibility in providing intensive community-based services and supports for youth with SED and their families.

The goals of the waiver include:

- Reducing out-of-home placements and inpatient psychiatric treatment by all child-serving agencies,
- Providing a more complete continuum of community-based services and supports for waiver participants with SED and their families to ensure families have access to parent partners and other flexible non-traditional support services as identified in a family-centered planning process, prevent entry and recidivism into the foster care system and relinquishment of parental custody, and improve the clinical and functional outcomes of children and adolescents.

The objective of the YES waiver is to provide community-based services in lieu of institutionalization.

Effective September 1, 2016, DSHS 1915(c) Medicaid waiver services are now administered directly by HHSC, the State Medicaid Agency. As a result there is no longer delegated authority between the two agencies.

The single State Medicaid Agency, 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 Medicaid and CHIP Services Division (the State's Medical Assistance Unit). 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, executing HHSC 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 inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:

HHSC distributed the YES Amendment Tribal Notification to the tribal representatives on September 4, 2020, in compliance with the 60-day federal and state requirements. The Tribal Notification provided contact information to request copies of the amendment, provide comments, and request information from the State via email, mail, or telephone. The State provides copies free of charge. The State did not receive any comments from the tribal representatives.

The Public Notice of Intent (PNI) for the YES amendment was published in the Texas Register ([https://texreg.sos.state.tx.us/public/regviewctx\\$regviewer.actionquery](https://texreg.sos.state.tx.us/public/regviewctx$regviewer.actionquery)) on September 25, 2020, allowing a 30-day comment period in compliance with federal and state requirements. The Texas Register is published weekly and is the journal of state agency rulemaking for Texas. In addition to activities related to rules, the Texas Register publishes various public notices including attorney general opinions, gubernatorial appointments, state agency requests for proposals and other documents, and it is used regularly by stakeholders. HHSC publishes all Medicaid waiver submissions in the Texas Register in addition to many other notices. The publication is available online and in hard copy at the Texas State Library and Archives Commission, the State Law Library, the Legislative Reference Library located in the State Capitol building, and the University of North Texas libraries. All of these sites are located in Austin, except for the University of North Texas, which is located in Denton. Printed copies of the Texas Register are also available through paid subscription; subscribers include cities, counties, and public libraries throughout the state. The PNI provided contact information to request copies of the amendment, provide comments, and request information from the State via email, mail, or telephone. The State provides copies free of charge.

The public comment period expired on October 25, 2020. During the public comment period, the State did not receive any public comments.

HHSC also sent a request to the HHSC Office of Social Services to distribute notice of the amendment to 290 local eligibility offices with instructions to post the notice in public areas on September 25, 2020. HHSC received confirmation of HHSC Office of Social Services distribution and local office posting of the notice.

The State posted the amendment online at <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>.

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:

Montalbano

First Name:

Kathi

Title:

Manager of Policy Development Support

Agency:

Texas Health and Human Services Commission

Address:

4900 North Lamar Blvd., Mail Code H-600

Address 2:

City:

Austin

State:

Texas

Zip:

78751

Phone:

(512) 730-7409

Ext:

TTY

Fax:

(512) 730-7472

E-mail:

kathi.montalbano@hhsc.state.tx.us

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Texas

Zip:

Phone:

Ext:

TTY

Fax:

E-mail:

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Texas

Zip:

Phone:

Ext:

TTY

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

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:

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:

The Youth Empowerment Services (YES) unit is operated within the State Medicaid Agency, Texas Health and Human Services Commission (HHSC) under the Behavioral Health Services Section. HHSC's Policy Development Support Unit (PDS) of the Medicaid/CHIP division is directly responsible for monitoring and oversight. PDS is responsible for approving all waiver amendments and renewals and the CMS-372(S) reports. In addition, PDS reviews all waiver program policies and operations and may require the program to modify, clarify, or provide additional information in considering approval or disapproval of proposed changes.

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:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

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

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

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

Appendix A: Waiver Administration and Operation

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

Not applicable

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

Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver

program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

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.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

N/A

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>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify:

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

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged		<input type="checkbox"/>	<input type="checkbox"/>
		Disabled (Physical)		<input type="checkbox"/>	<input type="checkbox"/>
		Disabled (Other)		<input type="checkbox"/>	<input type="checkbox"/>
Aged or Disabled, or Both - Specific Recognized Subgroups					
		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"/>
Intellectual Disability or Developmental Disability, or Both					
		Autism		<input type="checkbox"/>	<input type="checkbox"/>
		Developmental Disability		<input type="checkbox"/>	<input type="checkbox"/>
		Intellectual Disability		<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness					
		Mental Illness		<input type="checkbox"/>	<input type="checkbox"/>
		Serious Emotional Disturbance	3	18	

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

Not applicable.

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:

The local mental health authority, local behavioral health authority or entity providing targeted case management, under its agreement with HHSC, is required to ensure that waiver participants who turn 19 while in services begin to plan for transition to adult services at least six months before their 19th birthday. A transition plan must be developed in consultation with the waiver participant, the legally authorized representative and the future providers with adequate time to allow both current and future providers to transition the waiver participant into adult services without a disruption in services. The transition plan must include:

1. a summary of the mental health community services and treatment the waiver participant received as a youth,
2. the waiver participant's current status (e.g., diagnosis, medications, level of functioning) and unmet needs,
3. information from the waiver participant and the legally authorized representative regarding the waiver participant's strengths, preferences for mental health community services, and responsiveness to past interventions,
4. a plan of care that indicates the mental health and other community services the waiver participant will receive as an adult and ensures the waiver participant's continuity of services without disruption, and
5. submission of the transition plan to HHSC one month prior to the date of transition.

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.

The waiver is designed for waiver participants who need essential services and supports to continue to reside in his/her home. The waiver is not intended to serve individuals requiring intensive out-of-home residential treatment for an extended period of time.

Prior to initiating enrollment into the waiver, the local mental health authority or local behavioral health authority conducts a brief interview and administers the State authorized assessment tool to determine the applicant's current level of need. If the applicant and his/her family indicate that their expectations of services include a minimal use of out of home placement, and the assessment indicates that the waiver participant qualifies for the waiver, waiver enrollment will be pursued. The waiver participant and family will be informed that if the waiver participant is determined to be a danger to self or others, and adequate safety cannot be assured in the community, the waiver participant will be placed in a more restrictive setting.

Upon application for the YES program, the applicant and/or legally authorized representatives will be notified by the local mental health authority, local behavioral health authority, or entity providing targeted case management, verbally and in writing, of their right to a Medicaid fair hearing if they are not given a choice to receive waiver services, are denied waiver services or providers of their choice, or their waiver services are denied, suspended, reduced, or terminated.

Waiver participants must have a plan of care at a cost within the cost ceiling. For waiver participants 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 or institutional services. Third-party resources are examined during the treatment team meeting that occurs when a waiver participant is enrolled in the program, during each subsequent treatment team meeting, and as the waiver participant approaches the cost limit. If a waiver participant's needs exceed the cost limit, the treatment team would explore a referral for other services or institutional settings.

The waiver participant will be informed of their right, and given the opportunity, to request a fair hearing if the State proposes to terminate the waiver participant's waiver eligibility.

A change in the cost ceiling would require legislative or executive leadership approval. There are no planned changes to the cost ceiling at this time.

The individual cost limit is applied uniformly and fairly to all potentially eligible individuals.

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

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

The waiver is designed for waiver participants who need essential services and supports to continue to reside in his/her home. The waiver is not intended to serve individuals requiring intensive out-of-home residential treatment for an extended period of time.

Prior to initiating enrollment into the waiver, the local mental health authority or local behavioral health authority conducts a brief interview and administers the State authorized assessment tool to determine the applicant's current level of need. If the applicant and his/her family indicate that their expectations of services include a minimal use of out of home placement, and the assessment indicates that the waiver participant qualifies for the waiver, waiver enrollment will be pursued. The waiver participant and family will be informed that if the waiver participant is determined to be a danger to self or others, and adequate safety cannot be assured in the community, the waiver participant will be placed in a more restrictive setting.

Upon application for the YES program, the applicant and/or legally authorized representatives will be notified by the local mental health authority, local behavioral health authority, or entity providing targeted case management, verbally and in writing, of their right to a Medicaid fair hearing if they are not given a choice to receive waiver services, are denied waiver services or providers of their choice, or their waiver services are denied, suspended, reduced, or terminated.

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:

Waiver participants must have a plan of care at a cost within the cost ceiling. For waiver participants 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 or institutional services. Third-party resources are examined during the treatment team meeting that occurs when a waiver participant is enrolled in the program, during each subsequent treatment team meeting, and as the waiver participant approaches the cost limit. If a waiver participant’s needs exceed the cost limit, the treatment team would explore a referral for other services or institutional settings.

The waiver participant will be informed of their right, and given the opportunity, to request a fair hearing if the State proposes to terminate the waiver participant'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	2878
Year 2	3144
Year 3	3325
Year 4	3455
Year 5	3591

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	[]
Year 2	[]
Year 3	[]
Year 4	[]

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 5	[]

Appendix B: Participant Access and Eligibility

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

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

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Purpose(s) the state reserves capacity for:

Purposes
Children and adolescents at imminent risk of relinquishment to state conservatorship.

Appendix B: Participant Access and Eligibility

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

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

Children and adolescents at imminent risk of relinquishment to state conservatorship.

Purpose (*describe*):

This target group reserves capacity for children and adolescents who are at imminent risk of being relinquished to the conservatorship of the state.

Describe how the amount of reserved capacity was determined:

The State reserves capacity for this target group based on a percentage of the anticipated number of children who will enroll in the YES Waiver. Since this reserve group is new, there may be a need to adjust this number based on actual experience once children in state conservatorship begin enrollment.

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

Waiver Year	Capacity Reserved
Year 1	144
Year 2	157
Year 3	166
Year 4	173
Year 5	180

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:

The waiver capacity is allocated by service area to local mental health authorities or local behavioral health authorities. Allocation of waiver capacity is determined by HHSC using information on population, service demand / need and community infrastructure. HHSC reevaluates the allocation at least annually or more often as needed. Unused capacity will be reallocated to service areas with greater demand / need for services. On an annual basis, HHSC reviews each local mental health authority or local behavioral health authority's use of waiver slots and will reallocate unused slots in accordance with need.

The State assures that these practices do not violate the requirement that waiver participants have comparable access to waiver services across the geographic areas served by the waiver or impede the movement of participants across geographic areas.

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

The local mental health authorities or local behavioral health authorities must maintain an up to date inquiry list of waiver applicants living in the local service area who are seeking services through the waiver. The waiver capacity is allocated by service area to local mental health authorities or local behavioral health authorities. Vacancies are offered to waiver applicants on a first come, first served basis according to the chronological date of the waiver applicant's registration on the waiver inquiry list.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

§1634 State

SSI Criteria State

209(b) State

2. Miller Trust State.

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

No

Yes

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

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

Low income families with children as provided in §1931 of the Act

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

Optional state supplement recipients

Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

100% of the Federal poverty level (FPL)

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

Specify percentage:

Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)

Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)

Medically needy in 209(b) States (42 CFR §435.330)

Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)

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

Specify:

- Parent and Caretaker Relatives (435.110)
- Children's Medicaid (435.118)
- Medicaid for Pregnant Women (435.116)
- Medicaid for Transitioning Foster Care Youth (MTFCY) (1902(a)(10)(A)(ii)(XVII), 42 CFR 435.226)
- Former Foster Care Children (§1902(a)(10)(A)(i)(IX), 42 CFR 435.150)
- Earnings Transitional Medical Assistance (§1902(e)(1)(A), §1925, 42 CFR 435.112)
- Spousal Support Transitional (§1902(a)(10)(A)(i)(I), 42 CFR 435.115(f))
- Pickle (1939(a)(5)(E); 42 CFR 435.135; Sec 503 of P.L. 94-566)
- Foster Care and Adoption Assistance §1902(a)(10)(A)(i)(I), §473(b)(3), 42 CFR 435.145
- Reasonable Classification of Children Under 21 (1902(a)(10)(A)(ii)(I) and (IV), 42 CFR 435.222)
- Children with Non-IV-E Adoption Assistance (§1902(a)(10)(A)(ii)(VIII), 42 CFR 435.227)

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 spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility

for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal post-eligibility rules under §1924 of the Act.*

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

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

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

Use spousal post-eligibility rules under §1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

Not Applicable (see instructions)

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a

family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

Not Applicable (see instructions)*Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Texas uses the following limits:

- Covered services beyond the amount, duration, and scope of the Medicaid State Plan that are medically necessary are limited to the Medicaid State Plan rates;
- Services available from Medicaid providers, but recipient elects a non-Medicaid provider is zero;
- A deduction for incurred medically necessary non-covered medical or remedial care expenses will be allowed when the bill is incurred during a period which is no more than three months prior to the month of current application;
- A deduction for incurred medical expenses for dental services is based on the American Dental Association, West South Central Region, Survey of Fees at the 90th percentile. If an item is not listed on the Survey of Fees, the item is cleared through a Texas Health and Human Services dental consultant;
- A deduction for incurred medical expenses for durable medical equipment is based on the Medicare fee schedule for durable medical equipment. If an item is not listed on the schedule, the item is cleared through a Medicare contact at the CMS Regional Office; and
- Expenses incurred as the result of imposition of a transfer of assets penalty period is limited to zero.

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

Not Applicable

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

Specify:

Specify the amount of the allowance (select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

Not Applicable (see instructions)*Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Texas uses the following limits:

- Covered services beyond the amount, duration, and scope of the Medicaid State Plan that are medically necessary are limited to the Medicaid State Plan rates;
- Services available from Medicaid providers, but recipient elects a non-Medicaid provider is zero;
- A deduction for incurred medically necessary non-covered medical or remedial care expenses will be allowed when the bill is incurred during a period which is no more than three months prior to the month of current application;
- A deduction for incurred medical expenses for dental services is based on the American Dental Association, West South Central Region, Survey of Fees at the 90th percentile. If an item is not listed on the Survey of Fees, the item is cleared through a Texas Health and Human Services dental consultant;
- A deduction for incurred medical expenses for durable medical equipment is based on the Medicare fee schedule for durable medical equipment. If an item is not listed on the schedule, the item is cleared through a Medicare contact at the CMS Regional Office; and
- Expenses incurred as the result of imposition of a transfer of assets penalty period is limited to zero.

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

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

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

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

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

[Empty box for explanation of difference]

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

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

Select one:

Not Applicable (see instructions)*Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-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:

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 a government agency 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:

A Qualified Mental Health Professional-Community Services (QMHP-CS), as defined in Title 25 of the Texas Administrative Code, Part 1, Chapter 412, Subchapter G, is permitted to perform the initial evaluation assessment; however a licensed practitioner of the healing arts (LPHA) must review and make his or her own recommendation regarding level of care. The educational / professional qualifications of a LPHA are: physician, licensed clinical social worker, advanced practice registered nurse, physician assistant, licensed marriage and family therapist, licensed professional counselor and licensed psychologist. A medical director is required to verify / concur with any recommendation to deny level of care.

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.

In order to be eligible for the YES waiver, the individual must meet the following criteria:

Eligible waiver participants must have functional impairment or acute severe psychiatric symptomatology as identified on the Child and Adolescent Needs and Strengths Comprehensive Assessment. The Child and Adolescent Needs and Strengths Assessment is a set of standardized measures used in Texas to determine level of service for community-based children's mental health care.

The Children and Adolescent Needs and Strengths Comprehensive Assessment is a multi-purpose tool developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives utilizes a four level rating system for each of eight domains, designed to translate immediately into action items, with different action levels existing for different needs and strengths. It is designed to support care planning and level of care-decision making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

The Child and Adolescent Needs and Strengths Comprehensive Assessment utilizes a four point scale for needs (0 = no evidence of need, 1 = watchful waiting/prevention, 2 = action needed, 3 = immediate/intensive action needed), and a four point scale for strengths, (0 = centerpiece strength, 1 = useful strength, 2 = identified strengths, 3 = no strengths). The eight domains are:

- 1) Child's Risk Behavior
- 2) Child's Behavior/Emotional Health Needs
- 3) Child's Life Domain Functioning
- 4) Child's Strengths
- 5) Caregiver Strengths and Needs
- 6) Culture
- 7) Psychiatric Hospital History
- 8) Crisis History

For waiver level of care (clinical eligibility):

A. The applicant must score at the identified levels on the following domain:

- Child's Life Domain Functioning: 0 or 1 for Developmental OR 2 or 3 AND
- 0, 1, or 2 on Developmental Disability Module; Cognitive AND
- 0 or 1 on the Developmental Disability Module; Developmental

B. The applicant must score at the identified levels on one or more of the following domains:

- Child Risk Behaviors: 3 for Suicide Risk OR Self-Mutilation OR Other Self Harm
- Child Risk Behaviors: 2 or 3 for Danger to Others OR Sexual Aggression OR Fire Setting OR Delinquency
- Caregiver Strengths and Needs: 2 or 3 for Involvement with Care OR Family Stress OR Safety
- Life Domain Functioning: 2 or 3 for School AND
2 or 3 on School Module; School Behavior OR 2 or 3 on School Module; Attendance
- Psychiatric Hospitalization: 1 for Psychiatric Hospitalization AND
1, 2, or 3 on Psychiatric Hospitalization Module; Time Since Most Recent Discharge

C. The Medicaid eligible waiver participant must have a valid mental health diagnosis as the principle admitting diagnosis;

D. Outpatient therapy or partial hospitalization must have been attempted and failed, OR a psychiatrist must have documented reasons why an inpatient level of care is required; AND

E. The Medicaid eligible waiver participants must meet at least one of the following criteria:

- a) The Medicaid eligible waiver participant is presently a danger to self, demonstrated by at least one of the following:
 - Recent suicide attempt or active suicidal threats with a deadly plan and an absence of appropriate supervision or structure to prevent suicide;
 - Recent self-mutilative behavior or active threats of same with likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent self-mutilation (i.e., intentionally cutting / burning self);
 - Active hallucinations or delusions directing or likely to lead to serious self-harm or debilitating psychomotor agitation or retardation resulting in a significant inability to care of self; or
 - Significant inability to comply with prescribed medical health regimens due to concurrent psychiatric illness and such

failure to comply is potentially hazardous to the life of the waiver participant. A medical diagnosis must be treatable in a psychiatric setting.

b) The Medicaid eligible waiver participant is a danger to others. This behavior should be attributable to the waiver participant's primary diagnosis based on the most current Diagnostic and Statistical Manual and can be adequately treated only in a hospital setting. This danger is demonstrated by one of the following:

- Recent life-threatening action or active homicidal threats of same with a deadly plan and availability of means to accomplish the plan with the likelihood of acting on the threat;
- Recent serious assaultive or sadistic behavior or active threats of same with the likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent assaultive behavior; or
- Active hallucinations or delusions directing or likely to lead to serious harm of others.

c) The Medicaid eligible waiver participant exhibits acute onset of psychosis or severe thought disorientation, or there is significant clinical deterioration in the condition of someone with chronic psychosis rendering the waiver participant unmanageable and unable to cooperate in treatment, and the waiver participant is in need of assessment and treatment in a safe and therapeutic setting.

d) The Medicaid eligible waiver participant has a severe eating or substance abuse disorder, which requires 24-hours-a-day medical observation, supervision, and intervention.

e) The proposed treatment / therapy requires 24-hours-a-day medical observation, supervision, and intervention.

f) The Medicaid eligible waiver participant exhibits severe disorientation to person, place, or time.

g) The Medicaid eligible waiver participant's evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors, and other behaviors which may include physical, psychological, or sexual abuse.

h) Medicaid eligible waiver participants requires medication therapy, or complex, diagnostic evaluation where the youth's level of functioning precludes cooperation with the treatment regimen.

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.

The Texas Medicaid Inpatient Psychiatric Admission Instrument is used to determine level of care (clinical eligibility) for the Waiver along with the Child and Adolescent Needs and Strengths Comprehensive Assessment.

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:

Evaluation and Re-evaluation: A Qualified Mental Health Professional-Community Services (QMHP-CS), as defined in Title 25 of the Texas Administrative Code, Part 1, Chapter 412, Subchapter G, is permitted to perform the initial evaluation assessment; however a licensed practitioner of the healing arts (LPHA) must review and make his or her own recommendation regarding level of care (clinical eligibility). The educational / professional qualifications of a LPHA are: physician, licensed clinical social worker, advanced practice registered nurse, physician assistant, licensed marriage and family therapist, licensed professional counselor and licensed psychologist. A medical director is required to verify / concur with any recommendation to deny level of care (clinical eligibility).

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*):

HHSC provides training and technical assistance to local mental health authorities and local behavioral health authorities to educate them on performance of required functions such as evaluation and reevaluation of level of care (clinical eligibility). HHSC audits for the completion of evaluations and reevaluations of level of care (clinical eligibility) and uses a report to track timeliness of completion. The state created a level of care (clinical eligibility) expiration report to identify participants who's level of care (clinical eligibility) will expire in 30 days and need a reevaluation. This Clinical Management for Behavioral Health Services report is available to local mental health authorities, local behavioral health authority, or the entity providing targeted case management to improve timely reevaluations. Timeliness of completion is one factor examined. In addition. The Clinical Management for Behavioral Health Services system is automated and ensures that that a level of care (clinical eligibility) is current prior to authorizing payment.

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 reevaluations of level of care (clinical eligibility) are maintained by the following: HHSC, local mental health authority, local behavioral health authority and the entity providing targeted case management.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

B.a.1. Number and percent of waiver participants with an initial approved level of care (clinical eligibility) prior to receiving waiver services. N: Number of waiver participants with an initial approved level of care (clinical eligibility) prior to receiving services. D: Number of new waiver participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Clinical Management for Behavioral Health Services (CMBHS) 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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

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>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 30px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 30px;" type="text"/>

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

Performance Measures

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

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

Performance Measure:

B.b.1. Number and percent of waiver participants who re-enroll and receive a level of care re-evaluation prior to the expiration of their last level of care. N: Number of reviewed waiver participants who re-enroll and receive a level of care re-evaluation prior to the expiration of their last level of care. D: Number of re-enrolled waiver participants reviewed during the review period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review onsite and desk review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	<p>Representative Sample Confidence Interval =</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> The sample size produces results with a confidence level of 95% and a confidence interval of plus or minus five percent. </div>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually	<p>Stratified Describe Group:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Continuously and Ongoing	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

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

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

Performance Measures

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

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

Performance Measure:

B.c.1 Number and percent of newly enrolled individuals for whom initial LOC was completed prior to receipt of first service using approved processes and instruments. N: Number of newly enrolled individuals for whom initial LOC was completed prior to receipt of first service using approved processes and instruments. D: Number of newly enrolled individuals requiring an initial LOC determination.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Clinical Management for Behavioral Health Services (CMBHS) 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>):

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

Data Aggregation and Analysis:

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

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>):
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

HHSC waiver program staff confirms there is a valid medical necessity/level of care (clinical eligibility) before authorizing waiver services. Records of evaluations and reevaluations of level of care (clinical eligibility) are maintained in the following locations: HHSC, local mental health authority, local behavioral health authority, entity providing targeted case management, and the waiver provider agency. There is a Clinical Management for Behavioral Health Services (CMBHS) report available for local mental health authorities, local behavioral health authorities or the entity providing targeted case management to track and complete reevaluations prior expiration.

HHSC waiver program staff performs annual on-site or desk reviews of a sample size of waiver participant charts that produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent. Waiver participant charts are reviewed to ensure medical necessity/level of care records contain each level of care (clinical eligibility) assessment conducted and that the processes for determining level of care (clinical eligibility) for the waiver have been performed in accordance with waiver requirements.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

A level of care (clinical eligibility) must be approved by HHSC for each waiver participant prior to service delivery. Services delivered prior to the initial level of care (clinical eligibility) or during the time frame when a level of care (clinical eligibility) has expired are not reimbursed by HHSC. HHSC approves all levels of care (clinical eligibilities) and verifies that they are developed by qualified personnel using the prescribed tools and processes. Levels of care (clinical eligibilities) submitted that have not utilized approved instruments and processes are returned to the local mental health authority or local behavioral health authority for correction prior to being approved.

HHSC transitioned to approving level of care (clinical eligibility) determinations and managing plans of care through the Clinical Management for Behavioral Health Services (CMBHS) system in September 2014. This automated system requires the LMHA to use the state-approved instruments for submitting the level of care (clinical eligibility) evaluation to HHSC. This system also allows HHSC reviewers easy access to the approved instruments to verify medical necessity. HHSC can submit questions regarding a level of care (clinical eligibility) evaluation to the LMHA and receive clarifications electronically through Clinical Management for Behavioral Health Services (CMBHS). HHSC monitors and tracks timeliness of level of care (clinical eligibility) evaluations and reevaluations.

Individual problems may be discovered during monitoring activities by the State or any of the entities that have been delegated certain functions within performance measures of this appendix. The State requires a corrective action plan for any problems discovered during monitoring activities and are monitored until improvement is noted.

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>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="320 524 794 607" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="866 810 1340 893" type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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).

The local mental health authority, local behavioral health authority, or the entity providing targeted case management informs the waiver participant and their legally authorized representative of the services available under the waiver. Prior to enrollment, the local mental health authority, local behavioral health authority, or the entity providing targeted case management informs them of the right to seek admission to a psychiatric facility, the choice of provider agencies available under the waiver, and the right to change provider agencies if available. The waiver participant's and legally authorized representative's decision is then documented on the Freedom of Choice form and signed by the waiver participant and legally authorized representative. The form will also include a statement informing the waiver participant and legally authorized representative that if the situation deteriorates, hospitalization may still occur to ensure the safety of the waiver participant or others.

- 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 mental health authority, local behavioral health authority, or the entity providing targeted case management retains the Freedom of Choice form in the waiver participant's case record.

Appendix B: Participant Access and Eligibility

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

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

Under its contract with HHSC, the local mental health authority, local behavioral health authority, or the entity providing targeted case management is required to provide to waiver participants, including those with a disability (e.g., deafness, hard of hearing, and blindness), information about the waiver in a format and language that is easily understandable and based on the demographics of the population.

Documents that are provided to waiver participants throughout the enrollment process and service provision will be available in both English and Spanish. If the waiver participant's primary language is something other than English or Spanish, the local mental health authority, local behavioral health authority, or the entity providing targeted case management, case manager, and waiver service provider agency are required to enlist the assistance of an interpreter.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Other Service	Adaptive Aids and Supports		
Other Service	Community Living Supports (CLS)		
Other Service	Employment Assistance		
Other Service	Family Supports		
Other Service	Minor Home Modifications		
Other Service	Non-Medical Transportation		
Other Service	Paraprofessional Services		
Other Service	Specialized Therapies		
Other Service	Supportive Family-based Alternatives		
Other Service	Transitional Services		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09011 respite, out-of-home

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Respite is furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the waiver participant. Respite may be provided in:

- * Waiver participant's home or place of residence;
- * Private residence of a respite care provider, if that provider is a relative of the participant other than the waiver participant, spouse, legal guardian, or legally authorized representative;
- * Foster home verified by the Texas Department of Family and Protective Services licensed child placing agency;
- * General Residential Operations licensed by the Department of Family and Protective Services;
- * Day or overnight camps accredited by the American Camping Association;
- * Day or overnight camps licensed by DSHS;
- * Child care centers or homes licensed by the Department of Family and Protective Services; and
- * Child care homes registered with the Department of Family and Protective Services.

All settings must be located within the State of Texas.

The contracted waiver provider agency must approve and provide ongoing oversight of respite settings to ensure the safety of the setting. Respite services may be provided by a relative of the waiver participant other than the parents.

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

Payment may not be made for respite provided at the same time as other services that include care and supervision. Up to 720 consecutive or cumulative hours (30 days) of respite may be provided per individual service plan year. Temporary exceptions to the respite limit may be considered on a case by case basis. Such exceptions require the written approval of the HHSC YES waiver section. Exceptional circumstances may include, but are not limited to:

- parent dies or is hospitalized while the waiver participant is receiving respite care, or
- a catastrophic event, such as a hurricane, flood or other disaster, occurs while the waiver participant is receiving respite, temporarily disrupting the family's ability to provide shelter and care for the waiver participant.

Temporary exceptions will be granted for a defined time period. Costs for all waiver services, including any extended respite, cannot exceed the individual annual cost ceiling established under the waiver.

Respite services cannot be provided at the same time as supportive family-based alternatives, community living supports, supported employment, employment assistance, non-medical transportation, or paraprofessional services.

Federal financial participation is not to be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

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	Certified YES Waiver Provider Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Certified YES Waiver Provider Agency

Provider Qualifications

License *(specify):*

Foster home verified by the Texas Department of Family and Protective Services licensed child placing agency - Title 40 of the Texas Administrative Code, Part 19, Chapter 749;
 Child-placing agency licensed by the Department of Family and Protective Services - Title 40 of the Texas Administrative Code, Part 19, Chapter 749, Subchapter C;
 Camps licensed by DSHS - Title 25 of the Texas Administrative Code, Part 1, Chapter 265;
 Child-care centers licensed by the Department of Family and Protective Services - Title 40 of the Texas Administrative Code, Part 19, Chapter 746;
 Child care homes registered or licensed by the Department of Family and Protective Services - Title 40 of the Texas Administrative Code, Part 19, Chapter 747;
 General Residential Operations licensed by the Department of Family and Protective Services - Title 40 of the Texas Administrative Code, Part 19, Chapter 748.

Certificate (*specify*):

Waiver provider agency certified by HHSC as a local mental health authority or local behavioral health authority, or a comprehensive waiver provider.

Other Standard (*specify*):

Respite care personnel must be at least 18 years of age, have a current driver's license, and pass the criminal history and abuse registry checks as stipulated under item a in Appendix C-2.

Respite services may be provided by a relative of the waiver participant other than the parents, spouse, legal guardian, or legally authorized representative.

The contracted waiver provider agency must approve and provide ongoing oversight of respite settings to ensure the safety and appropriateness of the setting.

Respite care providers must complete training as required by HHSC.

Verification of Provider Qualifications

Entity Responsible for Verification:

YES Waiver Provider Agency
 HHSC

Frequency of Verification:

Annually

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews HHSC also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, HHSC uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

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):

[Empty text box]

HCBS Taxonomy:

Category 1:

03 Supported Employment

Sub-Category 1:

03021 ongoing supported employment, individual

Category 2:

[Empty text box]

Sub-Category 2:

[Empty text box]

Category 3:

[Empty text box]

Sub-Category 3:

[Empty text box]

Service Definition (Scope):

Category 4:

[Empty text box]

Sub-Category 4:

[Empty text box]

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

Transporting an individual to support the individual to be self-employed, work from home, or perform in a work setting is billable within the service. If an individual requires personal assistance with activities of daily living that are necessary to sustain the individual in the work environment and are incidental to the provision of supported employment, the supported employment provider may deliver personal assistance. In the state of Texas, this service is not available to individuals receiving waiver services under a program funded under section 110 of the Rehabilitation Act of 1973. Documentation is maintained in the individual's record that the service is not available to the individual under a program funded under the Individuals with Disabilities Education Act (20 U.S.C §1401 et seq.).

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

This service may not be provided to the individual with the individual present at the same time that respite, employment assistance, paraprofessional services, non-medical transportation, or community living supports is provided. Supported employment is delivered on an individual basis.

The service does not include sheltered work or other types of vocational services in specialized facilities, or for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- (A) incentive payments made to an employer to encourage hiring the individual;
- (B) payments that are passed through to the individual;
- (C) payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business; or
- (D) payments used to defray the expenses associated with starting up or operating a business.

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	Certified YES Waiver Provider Agency

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:

Certified YES Waiver Provider Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Waiver provider agency certified by HHSC as a local mental health authority, local behavioral health authority, or a comprehensive waiver provider.

Other Standard (*specify*):

The service provider must be at least 18 years of age, maintain a current driver's license and insurance if transporting the individual, and satisfy one of these options:

Option 1:
 - have a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and six month's paid or unpaid experience providing services to people with disabilities;

Option 2:
 - have an associate's degree in rehabilitation, business, marketing, or a related human services field; and one year of paid or unpaid experience providing services to people with disabilities; or

Option 3:
 - have a high school diploma or Certificate of High School Equivalency (GED credentials) and two years' of paid or unpaid experience providing services to people with disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Provider Agency
HHSC

Frequency of Verification:

Annually

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews HHSC also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, HHSC uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adaptive Aids and Supports

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Adaptive Aids and Supports are devices and supports recommended by the treatment team to effect a service under the approved service plan. The local mental health authority, local behavioral health authority, or the entity providing case management services submits the treatment team recommendations to HHSC for approval. The waiver participant and legally authorized representative, local mental health authority or local behavioral health authority, and waiver Adaptive Aids and Supports are one-time or occasional goods and/or services that are necessary to assist the participant to remain in the home and/or community and avoid an out-of-home placement. Adaptive Aids and Supports are provided in combination with other YES waiver services to decrease or eliminate barriers to services and increase the participant's access to their community. The case manager submits the treatment team recommendations to HHSC for approval. The waiver participant and legally authorized representative, local mental health authority or local behavioral health authority, and waiver provider agency all sign off on the recommendation before it is submitted to HHSC for approval. Individualized adaptive aids and supports address the waiver participant's needs that arise as a result of their serious emotional disturbance.

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

Room and board, normal household expenses and items not related to the amelioration of the waiver participant's disability are not covered.

Costs for all waiver services cannot exceed the individual annual cost ceiling established under the waiver.

Individuals who are under 21 years of age must purchase adaptive aids through the Texas Health Steps-- Comprehensive Care Program Early Periodic Screening, Diagnosis, and Treatment benefit (before purchasing adaptive aids through this waiver).

To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

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	Certified YES Waiver Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Adaptive Aids and Supports

Provider Category:

Agency

Provider Type:

Certified YES Waiver Provider Agency

Provider Qualifications

License *(specify):*

[Empty box]

Certificate (specify):

Waiver provider agency certified by HHSC as a local mental health authority, local behavioral health authority, or a comprehensive waiver provider.

Other Standard (specify):

Adaptive Aids and Supports are provided through the waiver provider agency, which purchases the aids and supports from appropriate outside vendors (e.g., in-store and on-line vendors). The waiver participant’s choice of services and service providers is determined during the treatment team meetings. Adaptive aids and supports may be provided by specialized groups or suppliers approved by the waiver provider agency, and specified in the waiver participant's plan of care and approved by HHSC.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver provider agency
HHSC

Frequency of Verification:

Annually.

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews HHSC also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, HHSC uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

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 Living Supports (CLS)

HCBS Taxonomy:

Category 1:

Sub-Category 1:

13 Participant Training 13010 participant training

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Community living supports are provided to the waiver participant and family to facilitate the waiver participant's achievement of his / her goals of community inclusion and remaining in their home. The supports may be provided in the waiver participant's residence or in community settings (including but not limited to libraries, city pools, camps, etc.) Community living supports provide assistance to the family caregiver in the disability-related care of the waiver participant, while facilitating the waiver participant's independence and integration in to the community. The training in skills related to activities of daily living, such as personal hygiene, household chores, and socialization may be included, if these skills are affected by the waiver participant's disability. Community living supports may also promote communication, relationship-building skills, and integration into community activities. These supports must be targeted at enabling the waiver participant to attain or maintain his / her maximum potential. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. Training may be provided to both the caregiver and the waiver participant, dependent upon the waiver participant's age, on the nature of the emotional disorder, the role of medications, and self-administration of medications. Training can also be provided to the waiver participant's primary caregivers to assist the caregivers in coping with and managing the waiver participant's emotional disturbance. This includes instruction on basic parenting skills and other forms of guidance. Basic parenting skills for this population are those practices and techniques that are intended to help parents who may also be experiencing personal stress and family difficulties with a child who is having difficulty with behavior, friendships, emotional regulation, or school performance.

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

Costs for all waiver services cannot exceed the individual annual cost ceiling established under the waiver. Community living supports cannot be provided at the same time employment assistance, non-medical transportation, respite, paraprofessional services, supported employment, and supportive family-based alternatives are provided.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified YES Waiver Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Living Supports (CLS)

Provider Category:

Agency

Provider Type:

Certified YES Waiver Provider Agency

Provider Qualifications

License (specify):

Not applicable

Certificate (specify):

Waiver provider agency certified by HHSC as a local mental health authority, local behavioral health authority, or a comprehensive waiver provider.

Other Standard (specify):

Community Living Supports (CLS) are provided either directly through the waiver provider agency staff or a direct service provider subcontracted with the waiver provider agency. The waiver participant’s choice of services and service providers is determined during the treatment team meetings.

Services will be provided by a credentialed Qualified Mental Health Professional - Community Services (QMHP-CS) or an Qualified Mental Health Professional - Community Services equivalent, and is defined as an individual who:

- (a) has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention;
- (b) is a registered nurse; or
- (c) has a Master's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver provider agency

HHSC

Frequency of Verification:

Annually

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews HHSC also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, HHSC uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Employment Assistance

HCBS Taxonomy:

Category 1:

03 Supported Employment

Sub-Category 1:

03010 job development

Category 2:

03 Supported Employment

Sub-Category 2:

03030 career planning

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Employment assistance is assistance provided to an individual as identified during the person-centered planning process to help the individual locate paid employment at or above minimum wage in an integrated employment setting in the community and meet the individual’s personal and career goals. Employment assistance includes:

- identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions;
- locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements; and
- contacting a prospective employer on behalf of an individual and negotiating the individual's employment.

Transporting the individual to help the individual locate paid employment in the community is a billable activity within the service.

Documentation is maintained in the individual's record that the service is not available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.).

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

This service may not be provided to the individual with the individual present at the same time that respite, supported employment, paraprofessional services, non-medical transportation, and community living supports is provided.

The service does not include incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- (A) incentive payments made to an employer to encourage hiring the individual;
- (B) payments that are passed through to the individual;
- (C) payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business; or
- (D) payments used to defray the expenses associated with starting up their own business.

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	Certified YES Waiver Provider Agency
Agency	Certified YES Waiver Provider Agency

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:

Certified YES Waiver Provider Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Waiver provider agency certified by HHSC as a local mental health authority or local behavioral health authority, or a comprehensive waiver provider.

Other Standard (*specify*):

The service provider must be at least 18 years of age, maintain a current driver's license and insurance if transporting the individual, and satisfy one of these options:

Option 1:
 - have a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and six month's paid or unpaid experience providing services to people with disabilities;

Option 2:
 - have an associate's degree in rehabilitation, business, marketing, or a related human services field; and one year of paid or unpaid experience providing services to people with disabilities; or

Option 3:
 - have a high school diploma or Certificate of High School Equivalency (GED credentials) and two years' of paid or unpaid experience providing services to people with disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver provider agency

 HHSC

Frequency of Verification:

Annually

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews HHSC also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, HHSC uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

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:

Certified YES Waiver Provider Agency

Provider Qualifications

License (specify):

Certificate (specify):

Waiver provider agency certified by HHSC as a local mental health authority or local behavioral health authority, or a comprehensive waiver provider.

Other Standard (specify):

The service provider must be at least 18 years of age, maintain a current driver's license and insurance if transporting the individual, and satisfy one of these options:

Option 1:
-have a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and six month's paid or unpaid experience providing services to people with disabilities;

Option 2:
-have an associate's degree in rehabilitation, business, marketing, or a related human services field; and one year of paid or unpaid experience providing services to people with disabilities; or

Option 3:
-have a high school diploma or Certificate of High School Equivalency (GED credentials) and two years' of paid or unpaid experience providing services to people with disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver provider agency
HHSC

Frequency of Verification:

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews HHSC also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, HHSC uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

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:

Family Supports

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09020 caregiver counseling and/or training

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Family supports provides peer mentoring and support to the primary caregivers; engages the family in the treatment process; models self-advocacy skills; provides information, referral and non-clinical skills training; maintains engagement; and assists in the identification of natural / non-traditional and community support systems.

Family Supports are peer-to-peer mentoring services and are not clinical skills training. By contrast, Community Living Supports consists of clinical skills training provided by a professional licensed clinician.

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

Costs for all waiver services cannot exceed the individual annual cost ceiling established under the waiver.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified YES Waiver Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Family Supports

Provider Category:

Agency

Provider Type:

Certified YES Waiver Provider Agency

Provider Qualifications

License (specify):

Not applicable

Certificate (specify):

Waiver provider agency certified by HHSC as a local mental health authority, local behavioral health authority, or a comprehensive waiver provider.

Other Standard (*specify*):

Family Supports are provided either directly through the waiver provider agency staff or a direct service provider subcontracted with the waiver provider agency. The waiver participant's choice of services and service providers is determined during the treatment team meetings.

The waiver provider agency will credential family support providers. Family supports providers must meet credentialing requirements including passing a criminal background check and reference checks. Family supports providers are skilled and experienced as the primary caregiver to children / adolescents with behavioral health challenges like those of the population of waiver participants, including a serious emotional disturbance. A family supports provider must have a high school diploma, or a high school equivalency certificate issued in accordance with the law of the issuing state; at least one cumulative year of receiving mental health community services for a mental health disorder or one cumulative year of experience navigating the mental health system as the parent or primary caregiver of a child / adolescent receiving mental health community services; and be under the direct clinical supervision of a master's level therapist.

Family supports providers must complete a training process through the waiver provider agency on program philosophy, policies and procedures, including reporting of critical incidents and abuse, neglect, and exploitation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver provider agency
HHSC

Frequency of Verification:

Annually
Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews HHSC also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, HHSC uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

specified in statute.

Service Title:

Minor Home Modifications

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Services related to addressing the waiver participant's needs that arise as a result of their serious emotional disturbance. These services contribute to the community functioning of waiver participants and thereby assist the waiver participants to avoid institutionalization. These services include home accessibility / safety adaptations - physical adaptations to the waiver participant's residence, required by the waiver participant's service plan, that are necessary to ensure the health, welfare and safety of the participant. May include alarm systems, alert systems, and other safety devices.

Minor home modifications must be age appropriate and related to specific therapeutic goals. The provider agency will be required to maintain written documentation of reasonable cost for services.

Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

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

Room and board, normal household expenses, and items not related to the amelioration of the waiver participant's disability are not covered.

Costs for all waiver services cannot exceed the individual annual cost ceiling established under the waiver.

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified YES Waiver Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Minor Home Modifications

Provider Category:

Agency

Provider Type:

Certified YES Waiver Provider Agency

Provider Qualifications

License (specify):

Certificate (specify):

Waiver provider agency certified by HHSC as a local mental health authority, local behavioral health authority, or a comprehensive waiver provider.

Other Standard (specify):

Minor Home Modifications are provided either directly through the waiver provider agency staff or an outside vendor subcontracted with the waiver provider agency (e.g., licensed contractor or licensed alarm system provider). The waiver participant’s choice of services and service providers is determined during the treatment team meetings.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver provider agency

HHSC

Frequency of Verification:

Annually

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews HHSC also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, HHSC uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

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:

Non-Medical Transportation

HCBS Taxonomy:

Category 1:

15 Non-Medical Transportation

Sub-Category 1:

15010 non-medical transportation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Non-medical transportation enables waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This service is in addition to, and not instead of, medical transportation required under 42 CFR §431.53 and transportation services under the State Plan. Transportation services under the waiver are offered in accordance with the waiver participant's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

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

Waiver transportation services may not be substituted for medical transportation services defined under the State Plan. Payment for non-medical transportation services is limited to the costs of transportation needed to access a waiver service included in the waiver participant's service plan or access other activities and resources identified in the service plan. When the costs of transportation are included in the provider rate for another waiver service that the waiver participant is receiving at the same time, non-medical transportation services cannot be reimbursed under the waiver.

Non-medical transportation cannot be provided at the same time as employment assistance, supported employment, community living supports, and paraprofessional services is provided.

Costs for all waiver services cannot exceed the individual annual cost ceiling established under the waiver.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified YES Waiver Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Certified YES Waiver Provider Agency

Provider Qualifications

License (specify):

Transportation providers must have a valid Texas driver's license and insurance appropriate to the vehicle used to provide transportation.

Certificate (specify):

Waiver provider agency certified by HHSC as a local mental health authority, local behavioral health authority, or a comprehensive waiver provider.

Other Standard (specify):

Non-Medical Transportation is provided directly through the waiver provider agency staff or a direct service provider subcontracted with the waiver provider agency. The waiver participant's choice of services and service providers is determined during the treatment team meetings.

Transportation providers must be over age 18 years of age.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver provider agency

HHSC

Frequency of Verification:

Annually

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews HHSC also verified the qualifications of waiver provider agency employees and subcontractors.

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:

Paraprofessional Services

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10040 behavior support

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Services related to addressing the waiver participant's needs that arise as a result of their serious emotional disturbance. These services contribute to the community functioning of waiver participants and thereby assist the waiver participants to avoid institutionalization. The services are essential to promote community inclusion in typical child/youth activities and exceed what would normally be available for children in the community. The paraprofessional is a behavioral aide supporting the waiver participant to meet the behavioral goals outlined in their plan. The paraprofessional may model and coach appropriate behaviors. Paraprofessional services are provided under the direction of a licensed behavioral health professional.

Services include:

- Mentoring and coaching - Mentoring is provided by a person who has had additional training/experience working with children/youth with mental health problems. For example, a teenager with severe behavior problems may require mentoring from a person with behavioral management expertise.
- Paraprofessional Aide - This service may be reimbursed if delivered in a setting where provision of such support is not already required or included as a matter of practice. The aide assists the waiver participant in preventing and managing behaviors stemming from serious emotional disturbance that create barriers to inclusion in integrated community activities such as after-school care or day care.

Job placement- assistance in finding employment. Job placement can be provided by the paraprofessional to assist the waiver participant with developing a resume and completing applications. Job placement is not supported employment or employment assistance.

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

Paraprofessional services cannot be provided at the same time respite, supported employment, employment assistance, community living supports, and non-medical transportation is provided. Costs for all waiver services cannot exceed the individual annual cost ceiling established under the waiver.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified YES Waiver Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Paraprofessional Services

Provider Category:

Agency

Provider Type:

Certified YES Waiver Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Waiver provider agency certified by HHSC as a local mental health authority, local behavioral health authority, or a comprehensive waiver provider.

Other Standard *(specify):*

Paraprofessional services are provided directly through the waiver provider agency staff or a direct service provider subcontracted with the waiver provider agency. The waiver participant’s choice of services and service providers is determined during the treatment team meetings.

A paraprofessional must meet the following qualifications:

- (A) Be at least 18 years of age;
- (B) Have received:
 - (i) A high school diploma; or
 - (ii) A high school equivalency certificate issued in accordance with the law of the issuing state;
- (C) Have a minimum of one year of documented full-time experience working with SED population. Experience may be considered if the documented experience includes activities that are comparable to services specified under the service definition;
- (D) Demonstrate competency in the provision and documentation of the specified or comparable service. Competency is assessed and documented by the waiver provider agency and reviewed by HHSC; and
- (E) Have received required training which includes, at a minimum:
 - (i) Orientation prior to delivering services; and
 - (ii) Systems of care and wraparound training within six months of hire.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver provider agency

HHSC

Frequency of Verification:

Annually

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews HHSC also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, HHSC uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

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:

Specialized Therapies

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11130 other therapies

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Services to waiver participants to assist them in meeting recovery goals. The intent of these services is to maintain or improve health, welfare, and/or effective functioning in the community. These services include:

- Art Therapy
- Music Therapy
- Animal-assisted Therapy
- Recreational Therapy
- Nutritional Counseling

Art Therapy: Art therapy is a human service profession in which waiver participants, facilitated by the art therapist, use art media, the creative process, and the resulting artwork to explore their feelings, reconcile emotional conflicts, foster self-awareness, manage behavior, develop social skills, improve reality orientation, reduce anxiety, and increase self-esteem.

Music Therapy: Music therapy utilizes musical or rhythmic interventions specifically selected by a registered music therapist to accomplish the restoration, maintenance, or improvement of social or emotional functioning, mental processing, or physical health. Music therapy is a prescribed use of music to therapeutically address physical, psychological, cognitive, or social functioning to optimize the individual's quality of life, improve functioning on all levels, enhance well being and foster independence. Music therapy provides an opportunity to move from isolation into active participation through an increase in verbal and nonverbal communication, social expression, behavioral and social functioning, and self awareness. Reductions are noted in maladaptive behaviors, anxiety, and stress among disabled individuals participating in music therapy. The reduction of maladaptive behaviors and improved social functioning assists a waiver participant to integrate into the community and to be less dependent upon others to monitor and intervene in social and community settings. It also encourages the improvement of communication skills for the individual.

Animal-Assisted Therapy: In animal assisted therapy, animals are utilized in goal directed treatment sessions, as a modality, to facilitate optimal physical, cognitive, social and emotional outcomes of a waiver participant such as increasing self-esteem and motivation, and reducing stress. Animal-assisted therapy is delivered in a variety of settings by specifically trained individuals in association with animals that meet specific criteria and in accordance with guidelines established by the American Veterinary Medical Association. Example programs include, but are not limited to Therapeutic Horseback Riding and Pet Partners.

Recreational Therapy: Recreational therapy helps to develop leisure time in ways that enhance health, independence, and well-being. Recreational therapy is a prescribed use of recreational and other activities as a treatment intervention to improve the functional living competence of persons with physical, mental, emotional, and/or social disadvantages. Treatment is designed to restore, remediate, or habilitate improvement in functioning and independence while reducing or eliminating the effects of an illness or a disability.

Nutritional Counseling: Nutritional counseling assists waiver participants in meeting their basic and/or special therapeutic nutritional needs. This includes, but is not limited to counseling waiver participants in nutrition principles, dietary plans, and food selection and economics.

This service is not available under a program funded under the IDEA (20 U.S.C 1401 et seq.).

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

Costs for all waiver services cannot exceed the individual annual cost ceiling established under the waiver.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified YES Waiver Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Therapies

Provider Category:

Agency

Provider Type:

Certified YES Waiver Provider Agency

Provider Qualifications

License (specify):

Licensed professionals, with documented training and experience relative to the specific service provided. These may include: licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, registered nurse, licensed vocational nurses, physical therapists, occupational therapists, or licensed dietitians.

Nutritional counseling is delivered by a registered, licensed, or provisionally licensed dietitian. The Texas Board of Examiners of Dietitians licenses and issues licenses for dietitians.

Or:

A person may also qualify to provide each specified professional service by meeting the appropriate certification standard listed below.

Certificate (specify):

Waiver provider agency certified by HHSC as a local mental health authority, local behavioral health authority, or a comprehensive waiver provider.

*Art Therapist certified by the Art Therapy Credentials Board (ATCB).

*Music Therapist certified by the Certification Board for Music Therapists (CBMT).

*Animal-Assisted Therapy providers and their animals must be appropriately trained and obtain certification specific to the type of program and animal(s) involved. Example certification programs include, but are not limited to: Pet Partners program, Equine Assisted Growth and Learning Association (EAGALA), and the Professional Association of Therapeutic Horsemanship International (PATH International).

*Recreational Therapist certified by the National Council of Therapeutic Recreation Certification (NCTRS) or Therapeutic Recreation Specialist Texas Certified (TRS/TXC) by Consortium for Therapeutic Recreation/Activities Certification, Inc. (CTRAC).

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver provider agency
 HHSC

Frequency of Verification:

Annually

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews HHSC also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, HHSC uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

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:

Supportive Family-based Alternatives

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11130 other therapies

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Supportive family-based alternatives are designed to provide therapeutic support to the waiver participant and to model appropriate behaviors for the waiver participant's family with the objective of enabling the waiver participant to successfully return to their family and live in the community with their family. Supportive family-based alternatives include services required for a waiver participant to temporarily reside within in a home other than the home of their family. The Child-Placing Agency will recruit, train and certify the support family and coordinate with the waiver participant's family. The support family must include at least one adult living in the home and no more than four non-related individuals may live in the home. The support family must have legal responsibility for the residence and either own or lease the residence. The home must be located in a typical residence in the community and provide an environment that assures community integration, health, safety and welfare of the waiver participant. The support family must provide services as authorized in the waiver participant's service plan. Services may include:

- * Age and individually appropriate guidance regarding and / or assistance with the activities of daily living and instrumental activities of daily living (ambulating, bathing, dressing, eating, getting in/out of bed, grooming, personal hygiene, money management, toileting, communicating, performing household chores, and managing medications)
- * Securing and providing transportation
- * Reinforcement of counseling, therapy, and related activities
- * Assistance with medications and performance of tasks delegated by a registered nurse or physician
- * Supervision of the waiver participant for safety and security
- * Facilitating inclusion in community activities, social interaction, use of natural supports, participation in leisure activities, and development of socially valued behaviors
- * Assistance in accessing community and school resources

The cost of transportation is included in the provider rate. HHSC reviews the monthly billing claims to ensure no other claims are filed for transportation when supportive family-based alternatives is billed.

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

Supportive family-based alternatives must be prior authorized by HHSC. Room and board is not included in the payment for supportive family-based alternatives. Waiver participants are responsible for their room and board costs. A waiver participant may not receive respite or community living supports while receiving supportive family-based alternatives. Waiver participants eligible for, or receiving, Title IV-E services cannot receive supportive family-based alternatives. Supportive family-based alternatives may be authorized for up to 90 consecutive or cumulative days per individual service plan year, with individual exceptions possible on a case-by-case basis, if recommended by the local mental health authority or local behavioral health authority and prior approved by HHSC.

Costs for all waiver services, including any extended Supportive Family-based Alternatives cannot exceed the individual annual cost ceiling established under the waiver.

Supportive family-based alternatives cannot be provided at the same time community living supports and respite is provided.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified YES Waiver Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Supportive Family-based Alternatives

Provider Category:

Agency

Provider Type:

Certified YES Waiver Provider Agency

Provider Qualifications

License (*specify*):

Foster home verified by a Texas Department of Family and Protective Services licensed Child Placing Agency - Title 40 of the Texas Administrative Code, Part 19, Chapter 749.

Child-Placing Agency licensed by the Texas Department of Family and Protective Services - Title 40 of the Texas Administrative Code, Part 19, Chapter 749, Subchapter C.

Certificate (*specify*):

Waiver provider agency certified by HHSC as a local mental health authority, local behavioral health authority, or a comprehensive waiver provider.

Other Standard (*specify*):

Supportive family-based alternatives providers must be age 18 or over and not the parent, spouse, legal guardian, or legally authorized representative of the waiver participant; must have CPR and first aid training; pass a criminal background check, have a current Texas driver's license and insurance (if transporting the waiver participant).

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver provider agency

HHSC

Frequency of Verification:

Annually

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews HHSC also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, HHSC uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

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:

Transitional Services

HCBS Taxonomy:

Category 1:

16 Community Transition Services

Sub-Category 1:

16010 community transition services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

A one-time non-recurring allowable expense when a waiver participant transitions from an institution, provider-operated setting, or family home to their own private community residence. Assistance may include:

- * utility and security deposits for the home/apartment
- * needed household items such as linens and cooking utensils
- * essential furnishings
- * moving expenses
- * services necessary to ensure health and safety in the apartment/home (e.g., pest eradication, allergen control, one-time cleaning)

Services will be provided by the waiver provider agency. The waiver provider agency must demonstrate to HHSC that services provided meet the requirements of the approved plan of care and are of reasonable cost.

Transitional services may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of those items and services are inherent to the service they are already providing. Transitional services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

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

Transition services is limited to \$2,500 dollars per waiver participant. Costs for all waiver services cannot exceed the individual annual cost ceiling established under the waiver.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified YES Waiver Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transitional Services

Provider Category:

Agency

Provider Type:

Certified YES Waiver Provider Agency

Provider Qualifications

License (specify):

Certificate (specify):

Waiver provider agency certified by HHSC as a local mental health authority, local behavioral health authority, or a comprehensive waiver provider.

Other Standard (specify):

Transitional services are provided either directly through the waiver provider agency staff or an outside vendor subcontracted with the waiver provider agency (e.g., furniture store, grocery store, or moving company). The waiver participant's choice of services and service providers is determined during the treatment team meetings.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver provider agency

HHSC

Frequency of Verification:

Annually

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews HHSC also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, HHSC uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

Appendix C: Participant Services

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

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

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

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

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

As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

As a primary care case management system service under a concurrent managed care authority. *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:

It is delivered under the Medicaid State Plan as a targeted case management service by the local mental health authority, local behavioral health authority or entity providing targeted case management.

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):

- (a) A criminal history check is conducted for all direct service providers by the waiver provider agency prior to employment or assignment regardless of the activities the person will be performing.
- (b) The criminal history check utilizes a statewide database maintained by the Texas Department of Public Safety. If the person lived outside the state of Texas at any time during the previous two years, then the criminal history check will include submission of fingerprints to the Federal Bureau of Investigations. A person who has been convicted of any of the criminal offenses delineated in Title 25 of the Texas Administrative Code, Part 1, Chapter 414, Subchapter K may not be employed or serve as a volunteer or intern.
- (c) The waiver provider agency is responsible for conducting criminal history checks for all waiver service providers by utilizing the statewide database maintained by the Texas Department of Public Safety. The waiver provider agency is required to maintain documentation of the criminal history checks. During the annual review, HHSC will monitor waiver service provider agencies 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):

Texas maintains two statewide abuse and misconduct registries:

- 1) Nurse Aide Registry maintained by the Department of Aging and Disability Services
- 2) Employee Misconduct Registry maintained by the Department of Aging and Disability Services.

A registry check is conducted for all employees, volunteers, and contracted providers prior to employment or assignment regardless of the activities the person will be performing. A person who is listed as having a finding entered into the Nurse Aide Registry concerning abuse, neglect, exploitation, or misconduct of a consumer or misappropriation of property may not be employed or serve as a volunteer or intern. A person who is listed in the Employee Misconduct Registry as having abused, neglected, or exploited a consumer may not be employed or serve as a volunteer or intern. (See Texas Health and Safety Code Sections 250.003 and 253.008)

The waiver provider agencies are required to conduct screening against the relevant registry. During the annual review, HHSC monitors the waiver provider agencies for completion of registry checks as required.

Waiver provider agencies must also screen all employees for exclusion prior to hiring and on an ongoing monthly basis by searching both the state and federal lists of excluded individuals and entities. If any exclusion is found it must immediately be reported.

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).

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.*

Self-directed

Agency-operated

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.

Respite and non-medical transportation, may be provided by a relative of the waiver participant other than the natural or adoptive parents or legal guardian. If a relative provides the service, they must subcontract with the waiver provider agency. The relative must meet qualifications for the service being provided as outlined in Appendix C-1/C-3, have a current driver's license, and pass the criminal history and abuse registry checks as stipulated under item a in Appendix C-2. The relative is required to complete the same training required by HHSC of all direct service providers.

Prior to the provision of respite or non-medical transportation services by the relative, the waiver participant's service plan must identify the need for the service and the relative as a provider of the service.

After the provision of the services the legally authorized representative must sign a form indicating the date(s), time, and duration of the provision of services. The form will also include a statement as to the location of service provision (e.g., relative's home, waiver participant's home).

HHSC waiver staff review a sample of claims to ensure that all waiver services were delivered according to the service plan and ensuring services are furnished in the best interest of the waiver participant.

Other policy.

Specify:

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

Waiver provider agencies must contract with the single State Medicaid Agency and the operating agency, HHSC. HHSC manages the provider enrollment process. A qualified provider may submit an application at any time. HHSC posts information on the provider agency enrollment process and requirements on the electronic state business daily and sends periodic notices to provider associations, communities and advocacy groups. In addition, providers may contact HHSC directly at any time during the year to obtain an application. Qualified waiver provider agencies agree to provide all YES program services.

This model of service delivery accomplishes the following for YES program consumers:

- * ensures the availability of each service in all counties included under the waiver;
- * recognizes that a vast majority of waiver participants 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 the waiver participant's service needs as provider agencies are required to make all services available when and as they are needed by the waiver participants;
- * establishes a single point of accountability for provision of needed services; and
- * decreases administrative costs.

In addition to promoting efficient service delivery, the YES program service delivery model does not compromise a waiver participant's choice of qualified provider agencies or providers of waiver services. Provider agencies are enrolled in the YES program through an open enrollment process, which includes all willing, qualified provider agencies. In all counties, waiver participants have a choice between at least two provider agencies if available.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

C.a.1. Number and percent of waiver provider agencies that initially meet licensing/certification requirements for the provision of waiver services. N: Number of waiver provider agencies that initially meet licensing/certification requirements for the provision of waiver services. D: Number of new waiver provider agencies.

Data Source (Select one):

On-site observations, interviews, 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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
Other Specify:	Annually	Stratified Describe Group:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

C.a.2. Number and percent of waiver provider agencies that continue to meet required licensing/certification standards for provision of waiver services. N: Number of waiver provider agencies that continue to meet required licensing/certification standards for provision of waiver services. D: Number of waiver provider agencies.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews, desk or onsite

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

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>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

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

Performance Measure:

C.a.3. Number and percent of waiver provider agencies that have a process to complete annual criminal history and employee misconduct checks. N: Number of waiver provider agencies that have a process to complete annual criminal history and employee misconduct checks. D: Number of waiver provider agencies.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Review On-site or Desk Review

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

		<input type="text"/>
	<p>Other Specify:</p> <input type="text"/>	

Data Aggregation and Analysis:

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

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

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

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

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

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

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

Performance Measure:

C.c.2. Number and percent of waiver provider agencies that have a process that ensures direct service providers meet state requirements for provider training. N: Number of waiver provider agencies that have a process that ensures that direct service providers meet state requirements for provider training. D: Number of waiver provider agencies.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews, desk or onsite

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

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

C.c.1. Number and percent of direct service providers trained in the requirements to report allegations, acts constituting, and methods to prevent abuse,neglect,or exploitation. N: Number of direct service providers trained in the requirements to report allegations, acts constituting, and methods to prevent abuse,neglect,or exploitation. D: Number of direct service providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review, desk or onsite

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

Sub-State Entity	Quarterly	Representative Sample Confidence Interval = Confidence interval: +/-5 Confidence level: 95%
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<div style="border: 1px solid black; width: 100%; height: 40px;"></div>

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

HHSC is responsible for the oversight of the waiver provider agencies and conducts annual onsite or desk reviews of the agencies regarding compliance with the functions delegated in the approved waiver. When harmful or non-compliant practices are identified, corrective action is taken to bring the waiver provider agency back into compliance. Waiver provider agencies must allow HHSC representatives and other state and federal agencies full and free access to direct service staff and all locations where the waiver provider agencies or subcontractors perform duties related to the waiver. These reviews examine the waiver providers policies, procedures and operation of the functions delegated in the approved waiver. The waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of the waiver provider agencies to ensure compliance with the waiver provider agreement. The reviews include an evaluation of the waiver participant clinical records to ensure that the waiver provider agency is providing adequate oversight and that the provider agency is responsive to findings. During these reviews HHSC verifies the qualifications of waiver provider agencies' employees and subcontractors, including compliance with requirements for criminal history and registry checks.

All waiver provider agencies and direct service staff are required to attend and satisfactorily complete the HHSC-sponsored YES waiver program specific training prior to the provision of waiver services or within other designated time frames. Waiver provider agencies must maintain training documentation in personnel files.

The YES waiver does not utilize non-licensed or non-certified providers; therefore, there is no performance measure for the sub-assurance "The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements".

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 HHSC or any entities that have been delegated certain functions within the performance measures of this appendix. The options for remediation are listed below:

For all performance measures related to provider qualifications, HHSC initiates remediation if an unqualified provider is discovered delivering services by requiring the waiver provider agency or the employing agency to terminate the provider's contract, recoup payment, transition waiver participants to qualified providers, and refer to the Office of Inspector General if appropriate. These actions pertain to both initial credentialing and re-credentialing requirements.

During its annual onsite or desk reviews, HHSC reviews a waiver provider agency's compliance with YES waiver requirements. If HHSC finds a waiver provider agency to be out of compliance, HHSC includes the information in the official site review report, which is provided to the waiver provider agency and retained in HHSC records. The waiver provider agency must submit a plan of correction to HHSC no later than 30 days after the issuance of the site review report. This plan of correction must explain how the provider will (1) come into compliance with training requirements within 30 days, and (2) prevent future noncompliance. HHSC approves this plan of correction and requires the waiver provider to submit documentation of its progress addressing the concerns included in the site review report. The waiver provider agency retains documentation and HHSC retains the plan of correction in its files.

If HHSC discovers that provider training was not received according to State requirements, HHSC requires the waiver provider agency to take action including, but not limited to, completion of training within specified timeframes, corrective action plans, and contract suspension or termination. If HHSC requires a corrective action plan for any of the sub assurances, the state continues to monitor the waiver provider agency to assure that the plan has resulted in a permanent system correction. This will be in addition to annual onsite or desk reviews.

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 following services will be limited to an annual maximum of \$5,000 combined: adaptive aids and supports and minor home modifications. The family and waiver participants choose the services that will most support the waiver participant's recovery goals specified in the plan of care. This limit is based on historical expenditures for comparable programs in Texas. The local mental health authority or local behavioral health authority informs waiver participants and legally authorized representatives of the limits upon enrollment.

The State does not plan to adjust this limit during the period the waiver is in effect. Should circumstances arise during the waiver period requiring adjustment of this limit, a waiver amendment will be submitted at that time.

Exceptions to this limit may be considered on a case by case basis, and written requests must be submitted to HHSC for written approval by the YES waiver program specialist and the HHSC Medicaid Services Unit Manager. Costs for all waiver services, including adaptive aids and supports and minor home modifications, cannot exceed the annual individual cost ceiling established under the waiver.

If necessary, a waiver participant's case manager will assist the waiver participant in locating additional resources through HHCC or the Department of Aging and Disability Services, or through family or local community organizations and other natural supports. To the extent that these efforts are unsuccessful, and the State finds that the absence of sufficient services prevents the State from assuring the waiver participant's health and welfare in the community, the waiver participant will be given an opportunity to request other services for which the waiver participant may be eligible. The waiver participant will be informed of and given the opportunity to request a fair hearing if the State proposes to terminate the waiver participant's waiver eligibility due to the inability of the waiver to assure health and welfare in the community.

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

HHSC is still assessing settings compliance in accordance with the transition plan.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Plan of Care

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

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Case management is delivered as a state plan service.

Case Managers have the following qualifications:

A case manager has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention,

OR

as of August 31, 2004, has received a high school diploma or equivalency certificate, three continuous years of documented full time experience in the provision of mental health targeted case management services, and demonstrated competency in the provision and documentation of targeted case management services.

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

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

The State allows the same entity to develop service plans and provide services only when there is no other entity available. When this occurs, HHSC requires a clear separation of provider and targeted case management functions. The distinct individual staff member providing targeted case management must be administratively separate from other provider functions and any related utilization review units and functions. In this document, service plan is used to include the wraparound plan that describes the strengths, needs and outcome statements of the youth and family. Service plan is also used to describe the service authorization document that identifies the specific waiver services, requested, and authorized units.

HHSC closely monitors arrangements where the same entity develops the service plan and provides services. HHSC reviews the administrative structure of the entity to ensure that there is a clear administrative separation of targeted case management and YES provider staff/functions before approving this arrangement. In addition, HHSC reviews the individuals who are performing targeted case management to ensure that they are not also providing YES services and are not under the administrative control of units providing YES waiver services. HHSC also reviews every service plan prior to approval to ensure that there is no evidence of conflict of interest. HHSC utilizes the following conflict of interest protections:

Individuals are informed they may choose among YES waiver providers in a service area at any time and are provided a list of available waiver services and a list of waiver service providers during enrollment, annually, and upon request. In addition, waiver participants can advocate for themselves and/or have an advocate present in service planning meetings.

HHSC has clear, well-known, and easily accessible means for waiver participants to make grievances and/or appeals to the State for assistance regarding concerns about denial of care, choice, quality, and outcomes. This includes a consumer bill of rights for mental health; published rules on consumer rights; and a toll-free line staffed by dedicated consumer rights representatives who can answer questions about rights, and assist the individual in resolving issues with YES waiver services or with filing a complaint regarding services. HHSC's Office of the Ombudsman is also available via a toll-free line to assist consumers in resolving issues with Medicaid providers or services. Information on these rights and grievance/appeal processes are provided in writing to each waiver participant.

Individuals are provided with the Handbook of Consumer Rights to ensure individuals are aware of the rights guaranteed to them while receiving services from HHSC. This handbook includes information regarding:

- Complaint/Grievance contact information;
- Appeal rights and the right to request a Medicaid Fair Hearing; and
- The rights to an individualized treatment plan, and the right to change providers at any time.

Entities that develop the service plans and provide services are not able to do so without prior approval by the State.

HHSC directly oversees the local mental health authority, local behavioral health authority or entity providing targeted case management. Oversight activities include an initial review, annual audit, and technical assistance. Technical assistance occurs during routine calls and quarterly best practice meetings between HHSC, the local mental health authority, local behavioral health authority, and the entities providing targeted case management. As part of oversight activities, HHSC monitors the separation of waiver provider and targeted case management functions and provides technical assistance as needed. HHSC also documents the number and types of appeals and the decisions regarding grievances and/or appeals.

HHSC reviews and approves all service plans. Service plans are submitted annually and updated at least every 90 days. HHSC analyzes the service plans submitted by case managers. If evidence of conflict of interest is identified, HHSC performs additional levels of review. These include direct contact with the case manager, direct contact with the supervisor of the case manager, onsite or desk reviews, and technical assistance.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

(a) At intake the waiver participant and legally authorized representative are informed of their rights and given the HHSC "Handbook of Consumer Rights." This handbook documents the waiver participant's and representative's right to participate in the development of the service plan. The documentation includes the waiver participant's right to request that other people be involved and the waiver participant's right to an explanation should the request be denied. The waiver participant and legally authorized representative are also informed of the conditions in which the right to request a Medicaid fair hearing apply.

(b) The local mental health authority, local behavioral health authority, entity providing targeted case management, case manager, and provider must include information obtained from the waiver participant and the legally authorized representative regarding the waiver participant's strengths, needs, natural supports, responsiveness to previous treatment, as well as preferences for, and objections to, specific treatment. The local mental health authority, local behavioral health authority, entity providing targeted case management, case manager, and provider must also identify the representative's or family member's needs for education and support services related to the waiver participant's emotional disturbance and facilitate the representative's or family member's receipt of the needed education and support services. The case manager and provider must involve the waiver participant and the legally authorized representative in all aspects of planning the waiver participant's treatment. If the waiver participant has requested the involvement of additional family members, then the provider must involve the family member in all aspects of planning the waiver participant's treatment.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

- (a) The waiver utilizes a wraparound, person-centered planning process, based on the National Wraparound Implementation Center (NWIC) model that addresses the waiver participant's unmet needs across all life domains. The participant's family, inclusive of the legally authorized representative, is a full and active partner and the expert on the waiver participant. The waiver participant and family select the treatment team members. Team membership is as open as the waiver participant and family chooses and may include other service providers, neighbors, clergy, and other people who currently do, or may in the future, provide support to the family. The waiver participant and family are included in all decision making. The initial wraparound plan development occurs after the team has met, been oriented to their roles on the team, identified family strengths through "family strengths discovery," and developed the crisis and safety plan. The wraparound plan includes outcomes, needs, and strategies including type, amount and frequency of service. The child and family team meets regularly and works together to revise the waiver participant's service plan. All waiver services are requested and approved in the service plan.
- (b) The waiver participant and family are informed of the services offered under the waiver at the time the local mental health authority or local behavioral health authority has determined that the child or adolescent may qualify to receive services under the waiver. The local mental health authority or local behavioral health staff person also informs the waiver participant and family of other treatment options such as hospitalization.
- (c) The team, which includes the waiver participant and family, identifies the waiver participant's needs. The team develops a measurable outcome for each need. The team decides how each outcome will be measured. Outcome statements are chosen by the waiver participant and family. Multiple strategies are generated and evaluated for the extent to which they will meet the need, achieve the measurable outcome, are community-based, are built on or incorporate strengths, and are consistent with the family's values and culture. The selected strategies including type, amount and frequency of service are based on the waiver participant's and family's preferences. The case manager, has primary responsibility for coordinating waiver and other services. During the wraparound planning meetings, the case manager explores third-party resources, including State Plan services.
- (d) The case manager will have the responsibility of coordinating the agreed upon services and supports.
- (e) The team assigns responsibility for completion of the action steps associated with each strategy. The case manager's responsibilities will include monitoring compliance with the plan by all members of the team.
- (f) The service plan is reviewed by the treatment team at least every 90 days. More frequent review may be required to address significant life events or changes in the waiver participant's or family's functioning.

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.

The Child and Adolescent - Needs and Strengths Comprehensive Assessment assesses risk and is completed upon enrollment and as the waiver participant's needs change, at a minimum every 90 days.

Because these youth are at high risk of placement for mental health treatment or are returning from such placements, crisis and safety plans are developed at the first meeting of the treatment teams. A crisis plan focuses on planning for, predicting, and preventing the occurrence of a crisis. Treatment team membership includes the waiver participant and caregiver to ensure that the waiver participant's and family's needs, strengths, and preferences are taken into consideration. Crisis plans are incorporated into the service plan with all team members knowing the roles they will play when crises arise. This helps to prevent crises and ensures crises are addressed immediately. If the waiver participants have safety or transition issues, safety and transition plans are also developed at the first meeting of the treatment team and incorporated into the service plan. When safety plans are needed, the safety of the waiver participant and all other family members must be addressed to the satisfaction of all team members. The service plan is revised to include additional supports and new strategies as needs change.

The service plan includes contingency plans for backup of services as well as a backup targeted case manager (Qualified Mental Health Provider), with their contact information.

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.

Upon determination of eligibility, the local mental health authority, local behavioral authority or entity providing targeted case management provides the waiver participant or legally authorized representative with a list of all waiver provider agencies within the geographic limitation identified in item 4.C. of the waiver application. This list is also provided annually at plan renewal and any time upon request of the waiver participant or legally authorized representative. The local mental health authority, local behavioral health authority or the entity providing targeted case management case manager assists the waiver participant in contacting providers and involving providers, as appropriate, in the development of the service plan.

The provision of the provider agency list and the final selection of a provider agency must be documented and retained in the waiver participant case record. HHSC I conducts periodic reviews to ensure that the local mental health authority, local behavioral health authority or the entity providing targeted case management objectively assists the waiver participant and legally authorized representative in the process of selecting a provider agency. HHSC provides a list of interested and qualified providers to the local mental health authority, local behavioral health authority or the entity providing targeted case management and provides updates to this list upon request.

The waiver participant's right to choose the service provider extends to the specific agency personnel that will be providing waiver services. The waiver participant's and legally authorized representative's selection of agency personnel is documented and retained in the waiver participant's case record.

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 YES waiver staff reviews and approves service plans and reviews all criteria, processes, and documentation requirements related to the service plan.

HHSC reviews a representative sample from local mental health authorities, local behavioral health authorities or entity providing targeted case management to ensure that service plans are developed based on the individual’s needs, outcomes, and strategies including type, amount and frequency of service. Case management services are also reviewed to ensure that child and family team meetings are held regularly and to ensure services are provided and progress is being made. HHSC reviews individual records to ensure that services are available and provided based on assessed needs and identified strategies. HHSC selects a representative sample size with a confidence level of 95% and a margin of error of 5%. HHSC reviews waiver participants served at each local mental health authority or local behavioral health authority and comprehensive waiver agencies by conducting annual onsite or desk reviews. Each service entity receives a quality management findings report and must submit a plan of correction within 30 days for each measure not meeting 90% compliance. If the plan of correction is not acceptable or corrective actions are not taken, HHSC will escalate communication to include leadership and contract management. Contractual actions may include correcting noted deficiencies, payment denial or recoupment, contract suspension, limiting provider expansion, and provider termination. Joint problem solving can include a Performance Improvement Plan (PIP). When a PIP is necessary, HHSC mandates specific corrective actions in correlation to specific performance measures.

Additionally, HHSC YES waiver staff reviews each waiver participant’s level of care (clinical eligibility) evaluation to verify medical necessity determination in-patient criteria has been met and that functional strengths and identified needs have been identified.

HHSC also reviews a sample of all service plans. HHSC performs annual on-site or desk reviews of the local mental health authorities, local behavioral health authorities or the entity providing targeted case management. HHSC aggregates the data quarterly and annually, discusses any significant findings, and prepares a remediation plan or improvement plan as needed.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

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

Medicaid agency

Operating agency

Case manager

Other

Specify:

The waiver provider agency, if applicable.

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.

Case managers monitor the day to day implementation of the service plan, waiver participant health and welfare, and assess how well services are meeting a waiver participant's needs and enabling the waiver participant to achieve the stated goals and outcomes. The case manager must meet in person with the waiver participant and child and family team at least once every 30 days. The case manager must also have at least one contact with the legally authorized representative every 30 days. The purpose of the required contacts is to verify:

- the safety and crisis plans are working as intended;
- services and supports are being implemented and provided in accordance with the service plan and continue to meet the waiver participant's needs, goals, and preferences;
- the waiver participant and legally authorized representative are satisfied with the implementation of services;
- the waiver participant's health and welfare are reasonably assured; and
- the waiver participant or legally authorized representative exercises free choice of providers and accesses non- waiver services including health services.

The entity providing targeted case management's quality management and supervisory staff provide oversight to the case manager's efforts ensuring that the required contacts occur, modifications to the service plan occur as necessary, and that the documentation generated by the case manager provides evidence of compliance with the requirements.

HHSC monitors service plans by annual onsite or desk reviews. In the course of review, HHSC compares service claims to each waiver participant's service plan to ensure that the services a waiver provider agency provides are consistent with authorized services and meet service definitions. HHSC ensures that all services indicated in the waiver participant's service plan are available and delivered. If there are discrepancies, HHSC follows up with the waiver provider agency and documents reasons in the waiver participant's review file. Freedom of provider choice is documented on the Provider Choice form. HHSC reviews the forms during annual onsite or desk reviews. The child and family team meets at least once every 30 days and, among other things, considers whether waiver services are meeting the waiver participant's needs and to ensure continued effectiveness of the safety and crisis plans. The case manager is responsible for coordinating all waiver and non-waiver services.

The child and family team must review a waiver participant's service plan every 90 days, or more frequently when necessary, to assess the appropriateness and adequacy of the identified services in light of the waiver participant's changing needs. Once reviewed, the service plan must be submitted to HHSC no less than every 90 days, even if the review did not result in changes to the plan.

HHSC approves all service plan. HHSC performs annual on-site or desk reviews of the local mental health authorities, local behavioral health authorities or the entity providing targeted case management as well as waiver provider agencies. HHSC aggregates the data quarterly and annually, discusses any significant findings, and prepares a remediation plan or improvement plan as needed.

- 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:*

HHSC conducts annual onsite or desk reviews of the local mental health authority, local behavioral health authority or entity providing targeted case management as well as waiver provider agencies. The reviews include an evaluation of the waiver participant case records to ensure that the provider agency is providing adequate oversight and that the provider agency is responsive to findings.

The State reviews crisis and safety plans during on-site and desk reviews to ensure the effectiveness of the participants' backup plans. Additionally, if the State identifies a trend in critical incidents, including hospitalizations, the State may specifically review crisis and safety plans and may request and monitor a corrective action plan.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

D.a.3. Number and percent of waiver participants with service plans that reflect the assessed personal goals. N: Number of waiver participants' service plans that reflect the assessed personal goals. D: Number of waiver participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and Desk Record Reviews

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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

Sub-State Entity	Quarterly	Representative Sample Confidence Interval = Confidence interval: +/-5 Confidence level: 95%
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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 type="text"/>

Performance Measure:

D.a.2. Number and percent of waiver participants with service plans that reflect the participant's assessed health and safety risk factors. N: Number of waiver participants with service plans that reflect the participant's assessed health and safety risk factors. D: Number of waiver participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and Desk Record Reviews

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>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/> Confidence interval: +/-5 Confidence level: 95%
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

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>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

D.a.1. Number and percent of waiver participants' service plan that reflect the participant's assessed needs. N: Number of waiver participants' service plans that reflect the participant's assessed needs. D: Number of waiver participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and Desk Record Reviews

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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample

		Confidence Interval = Confidence interval: +/-5 Confidence level: 95%
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

D.b.1. Number and percent of waiver participants' service plan (crisis and safety plan) developed during the first Child and Family Team meeting. N: Number of waiver participants' service plan (crisis and safety plan) developed during the first Child and Family Team meeting. D: Number of new waiver participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and Desk Record Reviews

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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = Confidence interval: +/-5 Confidence level: 95%
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify:

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

D.c.2. Number and percent of waiver participants' service plans that are revised

when warranted by changes in the participant's needs. N: Number of waiver participants' service plans that are revised when warranted by changes in the participant's need. D: Number of waiver participants with evidence of a change in need.

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and Desk Record Reviews

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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;"> Confidence interval: +/-5 Confidence level: 95% </div>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	

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

Performance Measure:

D.c.1. Number and percent of waiver participants' service plans that are reviewed and, if needed, revised every 90 days. N: Number and percent of waiver participants' service plans that are reviewed and, if needed, revised every 90 days. D: Number of waiver participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and Desk Record Reviews

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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		Confidence interval: +/-5 Confidence level: 95%
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope,

amount, duration and frequency specified in the service plan.

Performance Measures

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

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

Performance Measure:

D.d.1. Number and percent of waiver participants whose services are delivered according to the type, scope, amount, frequency, and duration specified in their service plans. N: Number of waiver participants whose services are delivered according to the type, scope, amount, frequency, and duration specified in their service plans. D: Number of waiver participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and Desk Record Reviews

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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = Confidence interval: +/-5 Confidence level: 95%
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify:

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

Data Aggregation and Analysis:

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

e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

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

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

Performance Measure:

D.e.2. Number and percent of waiver participants who are afforded choice among the home and community-based waiver services. N: Number of waiver participants who

are afforded choice among the home and community-based services. D: Number of waiver participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and Desk Record Reviews

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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;"> Confidence interval: +/-5 Confidence level: 95% </div>
Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	

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

Performance Measure:

D.e.3. Number and percent of waiver participants who are afforded choice of waiver provider agencies. N: Number of waiver participants who are afforded choice of waiver provider agencies. D: Number of waiver participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and Desk Record Reviews

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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/> Confidence interval: +/-5 Confidence level: 95%

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

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

Performance Measure:

D.e.1. Number and percent of waiver participants who are afforded choice between home and community-based services and institutional care. N: Number of waiver participants who are afforded choice between home and community-based services and institutional care. D: Number of waiver participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and Off-site Record Reviews

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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;"> Confidence interval: +/-5 Confidence level: 95% </div>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	

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>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

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>):
Other Specify: <input data-bbox="405 387 798 470" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="868 674 1260 757" type="text"/>

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

The case manager must monitor compliance with the overall service plan. This includes ensuring individual health and welfare, assessing how well services are meeting an individual’s needs, and enabling the individual to achieve the stated goals and outcomes.

The waiver provider agency will provide oversight of the case manager’s efforts to ensure that the required contacts occur, the service plan is modified as necessary, and that the documentation generated by the case manager provides evidence of compliance with the waiver requirements. The waiver provider agencies must maintain a copy of the service plan within the waiver participant’s clinical record.

HHSC conducts a review of each service plan prior to approving. If the plan is denied, HHSC will provide the waiver provider agency with justification of the denial. The waiver provider agency will submit a revision for further consideration and will inform the waiver participant of their right to a fair hearing. HHSC ensures all criteria, processes, and documentation requirements related to the service plan are met.

HHSC monitors service utilization data through an automated system in accordance with the approved service plan, as well as all service claims to verify that the service has been authorized. These reviews include verification of the plan’s service array, clinical eligibility and service documentation.

HHSC conducts annual on-site or desk reviews of the waiver provider agencies. The reviews include an evaluation of the waiver participant's case records to ensure that the waiver provider agencies are providing adequate oversight and that the waiver provider agency is responsive to findings. Deficiencies in service plan development, monitoring, or implementation are recorded and plans of correction are required of the local mental health authority and/or waiver provider agency within 30 days of HHSC’s formal findings report. HHSC annually obtains family satisfaction information regarding waiver services by sending a survey to all the individuals and their legally authorized representatives. Questions include, but are not limited to, satisfaction with frequency of treatment team meetings, if the team is assisting in obtaining natural supports, and assisting in reaching treatment goals. The timeframe for service plan deficiency corrections is dependent on the correction needed.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 HHSC or any of the entities that have been delegated certain functions within the performance measures of this appendix. The options for remediation are listed below:

If HHSC identifies that a waiver participant's service plan does not meet the participant's needs, goals, preferences, or risks, HHSC requires the local mental health authority, local behavioral health authority or the targeted case management entity to revise the service plan based on the assessment.

If HHSC identifies that a waiver participant's service plan was not developed according to standards set by the State, HHSC requires the targeted case management entity to revise the service plan prior to authorization. The State's system does not allow payment for services delivered to a person without a service plan. If a person receives services prior to the authorization of the initial service plan, the waiver provider agency will not receive payment for the service(s) rendered.

If a participant's case record does not indicate that the waiver participant was (1)provided choice of waiver services, (2)choice between waiver services and institutional care, or (3)informed of the right to change providers, the waiver provider agency is required develop a corrective action plan that indicates that all waiver participants are offered the above choices and informed of the right to change providers.

If the State requires a corrective action plan for any of the sub assurances, the state continues to monitor the waiver provider agencies to assure that the plan has resulted in a permanent system correction.

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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.

During the intake process the local mental health authority, local behavioral health authority or the entity providing targeted case management informs the applicant and the legally authorized representative verbally and in writing of the applicant's right to a fair hearing. In addition, the participant and legally authorized representative are informed verbally and in writing of the participant's right to a fair hearing. The applicant/waiver participant or legally authorized representative signs a Notification of Participant Rights document initially and at renewal that provides information as to how to file a grievance. If the waiver participant or legally authorized representative needs any assistance with the fair hearing process, the case manager provides assistance.

The following explains the process used by the entity providing targeted case management local mental health authority or local behavioral health authority when there is a request for a fair hearing.

The entity providing targeted case management, the local mental health authority or local behavioral health authority will send a standardized HHSC generated letter stating the conditions under which the applicant/waiver participant may request a fair hearing:

- If found to be eligible for the waiver, the applicant/waiver participant was not given the choice of waiver services as an alternative to institutional care;
- The applicant/waiver participant was not given the opportunity to receive services from the provider the applicant/waiver participant chose; or
- Waiver services were denied, suspended, reduced, or terminated.

An applicant whose request for eligibility for the waiver program is denied or is not acted upon with reasonable promptness, or a waiver participant whose waiver services have been terminated, suspended, or reduced by HHSC, is entitled to a fair hearing in accordance with Title 25 of the Texas Administrative Code, Part 1, Chapter 419, Subchapter A. The entity providing targeted case management, the local mental health authority or local behavioral health authority must notify the applicant/waiver participant and legally authorized representative of the right to a fair hearing, conducted in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, and Subchapter A. The notice informs the waiver participant of the right to continue to receive services while the hearing is pending and the actions the waiver participant or legally authorized representative must take for services to continue. Waiver participants submit the request for a fair hearing to HHSC. HHSC then assigns a fair hearing officer.

All notification letters and request forms are offered in both English and Spanish, or another language if requested.

HHSC retains a copy of the notice of adverse action taken and the notice to the applicant/waiver participant and legally authorized representative of the right to a fair hearing. If an applicant/waiver participant or legally authorized representative requests a fair hearing, a copy of the written request for a hearing is retained as well.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

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

HHSC operates the grievance/complaint system.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

HHSC Crisis Services and Client Rights Unit staff operates an 8am to 5pm toll free complaint and fair hearing phone line with TTY capabilities during the work week. Complaints can also be submitted via email or written correspondence and may be anonymous. (a) There is no restriction on the types of complaints that an individual or legally authorized representatives may register. (b) All complaints are acted upon in a timely fashion. Given the variety of complaints, there is no mandated time line for resolution to the complaint. (c) Crisis Services and Client Rights Staff have access to all departments and units to resolve the waiver participant's complaint. HHSC resolves complaints within ten business days of receipt unless circumstances outside of HHSC' control (e.g., unresponsiveness by the waiver participant) prevent resolution. If HHSC cannot resolve the complaint within ten business days, HHSC documents the reason(s) and continues its investigation until resolution.

Complaints involving allegations of abuse, neglect, or exploitation are referred immediately to the Texas Department of Family and Protective Services, the department with statutory responsibility for investigation of such allegations.

HHSC's Office of the Ombudsman assists the public when HHSC's normal complaint process cannot or does not satisfactorily resolve an issue. The waiver participant and their families also have the option of contacting the Office of the Ombudsman directly for assistance. The Ombudsman's services include:

- Conducting independent reviews of complaints concerning agency policies or practices;
- Ensuring policies and practices are consistent with the goals of HHSC;
- Ensuring waiver participants 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:

1. Member of the public, individual, or provider makes first contact with HHSC to request assistance with an issue or complaint.
2. If not able to resolve the issue or complaint, the Office of the Ombudsman may be contacted.
3. The Office of the Ombudsman provides an impartial review of actions taken by the program or department.
4. The Office of the Ombudsman seeks a resolution and may use mediation if appropriate. Often it is necessary for the Office of the Ombudsman to refer an issue to the appropriate department. If so, the Office of the Ombudsman will:
 - o Follows-up with the complainant to determine if a resolution has been achieved.
 - o Refers complainant to other available known resources.

Waiver participants are given the contact information verbally and in writing for HHSC Crisis Services and Client Rights Unit , the Department of Family and Protective Services, and the Office of the Ombudsman at intake, when requested, at annual renewal, and when a need is identified or thought to exist.

Waiver participants are informed that filing a grievance or making a complaint is not a prerequisite or substitute for a fair hearing.

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 waiver participants, legally authorized representatives, waiver provider agencies, local mental health authorities, local behavioral health authorities and entities providing targeted case management are provided with the 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 no later than one hour after having knowledge or suspicion, that a waiver participant has been or is being abused, neglected, or exploited. The local mental health authority, local behavioral health authority, entities providing targeted case management and waiver provider agencies are required to train staff on identifying, preventing, and reporting abuse, neglect, and exploitation.

Waiver provider agencies' contracts and local mental health authority, local behavioral health authority or the the entity providing targeted case management contracts include requirements to report to HHSC and if applicable other entities such as law enforcement or the Department of Family and Protective Services any incidents that result in substantial disruption of program operation involving or potentially affecting persons served by HHSC. Incidents include, but are not limited to: medical injuries, behavioral or psychiatric emergencies, allegations against client rights, criminal activities, death, restraints, property or vehicle loss or damage, medication errors, client departures, legal/juvenile justice department involvement, hospitalizations. All incidents involving waiver participants are to be reported to the program within 72 hours, by completing a Critical Incident Reporting form.

All instances of abuse, neglect, and exploitation must be reported to the Department of Family and Protective Services immediately as it is the designated investigative agency for all such reports. Once reports of abuse, neglect, and exploitation are filed with the Department of Family and Protective Services, the waiver provider agencies and local mental health authorities or local behavioral health authorities are required to submit accurate and timely information to HHSC in accordance with the Submission Calendar, as follows: within one business day after completion of the Client Abuse and Neglect Reporting form the information contained in the completed form, or if online access is unavailable, a copy of the completed form is sent to the HHSC Office Ombudsman, Consumer Rights and Services. In addition, waiver provider agencies are required to submit a Critical Incident Reporting form to the waiver program within 72 hours of a report of abuse, neglect, or exploitation.

In an instance in which the contractor must report abuse or neglect, investigations are conducted by the Department of Family and Protective Services. HHSC has a Memorandum of Understanding with the Department of Family and Protective Services that allows the waiver program to submit participant names to the Department of Family and Protective Services database quarterly. Department of Family and Protective Services provides HHSC a quarterly list of allegations and confirmed reports made involving waiver individuals. All Department of Family and Protective Services investigative reports are submitted to HHSC for review and follow-up on remediation.

If the perpetrator or alleged perpetrator is an employee or agent of the waiver provider agency, local mental health authority, local behavioral health authority or the the entity providing targeted case management, the director shall ensure that the employee or agent is removed as a provider of services. The Department of Family and Protective Services submits a copy of the investigative report to HHSC and the director of the waiver provider agency, local mental health authority, local behavioral health authority or the entity providing targeted case management.

A Client Abuse and Neglect Reporting form is completed within 14 calendar days of the receipt of the investigative report or decision made after review or appeal using the Client Abuse and Neglect Reporting System Definitions and Classifications. Within one working day after completion of the Client Abuse and Neglect Reporting form, the administrator shall ensure that:

- (1) the information contained in the completed Client Abuse and Neglect Reporting form is entered into the Client Abuse and Neglect Reporting System; or
- (2) if access to the Client Abuse and Neglect Reporting System is unavailable, a copy of the completed Client Abuse and Neglect Reporting form is forwarded for data entry to the HHSC Office of Consumer Services and Rights Protection.

The director of the waiver provider agency, local mental health authority, local behavioral health authority or the entity providing targeted case management may not change a confirmed finding made by a Department of Family and Protective Services investigator. The director of the waiver provider agency, local mental health authority, local behavioral health authority or the entity providing targeted case management may request a review of the finding or the methodology used to conduct the investigation.

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 of admission into the waiver and annually thereafter, the waiver participant and the legally authorized representative are informed verbally and in writing of the process for reporting allegations of abuse, neglect, and exploitation and given the toll-free number for the Department of Family and Protective Services. Verbal and written communication of this information is documented on the Notification of Participant Rights form, bearing the date and signatures of the waiver participant and/or legally authorized representative and the staff person who provided this information. The form is filed in the waiver participant's case record with a copy for the local mental health authority's or local behavioral health authority's records.

The waiver participant and legally authorized representative are also given a copy of HHSC's "Handbook of Consumer Rights, Mental Health Services" in either English or Spanish as appropriate. In addition to receiving the rights handbook, the waiver participant and legally authorized representative are informed orally of all rights in his or her primary language using plain and simple terms. The method used to communicate the information is designed for effective communication, tailored to meet each person's ability to comprehend, and responsive to any visual or hearing impairment. Verbal communications of rights is documented on a form bearing the date and signatures of the waiver participant and/or legally authorized representative and the staff person who explained the rights. The form is filed in the waiver participant's case record. The provider repeats the explanation of rights, including giving the waiver participant a copy of the handbook and required documentation, at least annually.

The local mental health authority, the local behavioral health authority, the waiver provider agency and the entity providing targeted case management must post the following information. The name, telephone number, and mailing address of the provider's rights protection officer is prominently posted in every area that is frequented by waiver participants. Waiver participants desiring to contact the rights protection officer must be allowed access to the provider's telephones to do so.

Waiver provider agencies are required to ensure direct service staff are trained annually on critical incident reporting.

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.

Critical incidents are managed as part of the quality management oversight process by HHSC. Incidences which must be reported to HHSC include: Injury, Medical Emergency, Behavioral or Psychiatric Emergency (including psychiatric hospitalizations), Allegation against client rights, Criminal Activity, Death, Restraint, Property or Vehicle loss or damage, Medication Error, Client Departure (missing, runaway, attempted departure), and all incidences resulting in a report of abuse, neglect, or exploitation.

HHSC YES waiver staff are responsible for the review of critical event and incident reports. The staff evaluates reports on the basis of timeliness of report, as well as the nature of the response. If a waiver service provider was involved in the incident, the HHSC staff evaluates the report to ensure that the waiver provider agency followed approved HHSC protocols. If the responder responded inappropriately, a report must be made to the Department of Family and Protective Services and to the regulatory agency that is responsible for oversight and licensure of the specific provider.

Annually, HHSC does a comprehensive on-site or desk review of waiver provider agencies, local mental health authorities, local behavioral health authorities or the entity providing targeted case management, during which critical incident reports are reviewed. The Department of Family and Protective Services receives allegations of abuse, neglect, and exploitation of waiver participants from waiver providers. The Department of Family and Protective Services is statutorily responsible for review, investigation and response to those reports.

The Department of Family and Protective Services Investigations: Adult Protective Services, a division of the Department of Family and Protective Services, is responsible for investigating allegations of abuse, neglect, or exploitation of children, involving cases in which a waiver provider agency is alleged to have abused, neglected, or exploited an waiver participant. Adult Protective Services records and tracks reports of abuse, neglect, or exploitation.

The Department of Family and Protective Services assigns one of four priority levels to complaints at the time of the complaint intake. The Department of Family and Protective Services complaint investigators must contact the alleged victim by phone within 24 hours of intake. The investigator may change the priority level as a result of the phone contact. The Department of Family and Protective Services must make the initial face-to-face contact with the alleged victim based on the priority level. Priority one cases require response within 24 hours; priority two cases require response within three calendar days; priority three cases require response within 7 calendar days; and priority four cases require response within 14 calendar days. Depending on the severity of the allegation, the Department of Family and Protective Services investigations must be completed within 14 to 21 calendar days.

Under a Memorandum of Understanding between HHSC and the Department of Family and Protective Services, the Department of Family and Protective Services notifies HHSC of substantiated abuse, neglect, or exploitation complaints providing due process to the perpetrator. HHSC coordinates with Department of Family and Protective Services to determine the resolution of the abuse, neglect, or exploitation allegation. Waiver provider agencies are required to protect waiver participants from abuse, neglect, or exploitation under consumer rights rules and report potential incidences of abuse, neglect, or exploitation to the Department of Family and Protective Services.

The Department of Family and Protective Services investigator notifies the victim within the next business day of completing an investigation related to abuse, neglect, and exploitation. The investigator completes the Letter to the Victim and sends it to the victim, stating the outcome of the investigation and the appeal process. The investigator also sends a copy of the investigative report to the director of the waiver provider agency, local mental health authority, local behavioral health authority, or the entity providing targeted case management by close of business the next business day after the DFPS supervisor approves the investigation report. As part of the notification process, the investigator informs the waiver provider administrator or CEO of a service provider that is the subject of an investigation and whether the Department of Family and Protective Services will contact the local law enforcement agency and/or Office of Inspector General.

HHSC has a Memorandum of Understanding with the Department of Family and Protective Services that allows the waiver program to submit participant names to the Department of Family and Protective Services database quarterly. The Department of Family and Protective Services provides HHSC a quarterly list of allegations and confirmed reports made involving waiver individuals perpetrated by a waiver provider.

HHSC requests and reviews all Department of Family and Protective Services investigative reports and follows up on remediation for all confirmed allegations. If the perpetrator or alleged perpetrator is an employee or agent of the waiver provider agency, local mental health authority, local behavioral health authority, or the entity providing targeted case management, the entity shall ensure that disciplinary action is taken up to and including removing the perpetrator as a provider of

services.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

HHSC is the agency that is responsible for overseeing the reporting of and response to critical incidents that affect waiver participants. HHSC conducts risk assessment of the local mental health authority, local behavioral health authority or the entity providing targeted case management, and waiver provider agencies quarterly which includes a review of any reported critical incidents and events. HHSC will capture data from critical incidents and review on at least an annual basis.

The Quality Oversight Plan supports the creation of specific indicators related to each sub-assurance. Data from these critical incident reviews is gathered by HHSC. HHSC coordinates through formal Quality Review Team meetings to discuss findings and trends and, when necessary, to develop and monitor remediation plans.

In the case of critical incidents, waiver provider agencies are expected to take immediate action to resolve, when feasible, and to report to the appropriate state and/or law enforcement entities. The waiver program also requires waiver provider agencies to submit a Critical Incident Report form to HHSC within 72 hours of an incident.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

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

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In accordance with Title 25 of the Texas Administrative Code Chapter 415, Subchapter F: Interventions in Mental Health Services §415.254 and §415.256, the use of chemical and mechanical restraints and seclusion are generally prohibited with limited exceptions.

Title 25 of the Texas Administrative Code Chapter 412, Subchapter G: Mental Health Community Services Standards §412.312 (d) allows limited use of physical restraints only when: (1) necessary to prevent imminent death or substantial physical harm to the individual; or (2) necessary to prevent imminent death or substantial physical harm to another; and (3) less restrictive methods have been attempted and failed.

Use of restraints must be used in accordance with Title 25 of the Texas Administrative Code Chapter 415, Subchapter F.

When applied, restraints must be used for the shortest period of time necessary and terminated upon the participant demonstrating release behaviors specified by the ordering physician.

Title 25 of the Texas Administrative Code §415.253 defines personal restraint as, “ Any manual method by which a person holds or otherwise bodily applies physical pressure that immobilizes or reduces the ability of the individual to move his or her body or a portion of his or her body”. Personal restraint is used only as a last resort after less restrictive measures have been found to be ineffective or are judged unlikely to protect the waiver participant or others from harm. The intervention is used for the shortest period possible and terminated as soon as the waiver participant demonstrates the release behaviors specified by the ordering physician.

Waiver providers are trained in the safe use of personal restraint by the waiver provider agencies. Providers shall not use personal restraint unless it is necessary to intervene to prevent imminent probable death or substantial bodily harm to the waiver participant or imminent physical harm to another, and less restrictive methods have been tried and failed.

Providers shall not use more force than is necessary to prevent imminent harm and shall ensure the safety, well-being, and dignity of waiver participants who are personally restrained, including attention for personal needs.

The provider must take into consideration information that could contraindicate or otherwise affect the use of personal restraint, including information obtained during the initial assessment of each waiver participant at the time of admission or intake. This information includes, but is not limited to:

- (A) pre-existing medical conditions or any physical disabilities and limitations, including, without limitation, cognitive functioning, substance use disorders, obesity, or pregnancy, that would place the individual at greater risk during restraint;
- (B) any history of sexual abuse, physical abuse, neglect, trauma, or previous restraint that would place the individual at greater psychological risk during restraint;
- (C) cultural factors; and
- (D) information contained in a declaration for mental health treatment, if there is one.

A waiver participant held in restraint shall be under continuous direct observation. The provider shall ensure adequate breathing and circulation during restraint. An acceptable hold is one that engages one or more limbs close to the body to limit or prevent movement.

Provider shall record the following information in the waiver participant's record within 24 hours:

- * the circumstances leading to the use of personal restraint;
- * the specific behavior necessitating the restraint and the behavior required for release;
- * less restrictive interventions that were tried before restraint began;
- * the names of the providers who implemented the restraint;
- * the date and time the procedure began and ended; and

* the waiver participant's response.

The State requires a waiver provider agency to document use of restraints in a waiver participant’s case file within 24 hours after use of the restraints. The waiver provider agency must notify the waiver participant’s family and legally authorized representative within the same day. HHSC has a client rights hotline that is staffed to receive allegations of any violations or perceived violations of a client’s rights. The waiver provider agency provides the hotline number to each waiver participant and legally authorized representative. HHSC must investigate all complaints made to the client rights hotline. Suspicion of abuse, neglect, or exploitation in relation to the use of a restraint is reported to the Department of Family and Protective Services for investigation.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

HHSC is responsible for overseeing the use of personal restraints by waiver providers. The use of mechanical restraints and seclusion is prohibited in community settings. For General Residential Operations, the Department of Family and Protective Services is responsible for oversight of restraint.

HHSC’s oversight of personal restraint by the local mental health authority, local behavioral health authority or the entity providing targeted case management and by the waiver provider agencies is accomplished through the quarterly risk assessment. The use of personal restraint must be documented as a critical incident by the waiver provider agencies, local mental health authority, local behavioral health authority and the entity providing targeted case management and follow the procedures specified in Appendix G-1 for Critical Incident Reporting. Additionally, HHSC requires submission of the Critical Incident Reporting form to the program within 72 hours by the waiver provider agencies; local mental health authority, local behavioral health authority and the entity providing targeted case management in the use of personal restraint.

Use of unauthorized restraint and prohibited seclusion will be detected by record review and through complaints.

In the case of critical incidents, waiver provider agencies, local mental health authority, local behavioral health authority and the entity providing targeted case management are expected to take immediate action to resolve, when feasible, and to report to appropriate state and law enforcement entity.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one):*

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other

individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The State allows the use of restrictive interventions that are necessary to ensure the health, welfare and safety of the participant. The restrictive intervention must be identified and requested by the child and family team and identified as a strategy in the service plan (wraparound plan and/or crisis safety plan). Restrictive interventions are considered only if the participant is determined to be a danger to self or others, and adequate safety cannot be assured in the community. Examples of restrictive interventions include home accessibility / safety adaptations such as alarm systems, monitoring devices, door locks, and other devices.

The restrictive intervention must be clearly documented on the service plan (wraparound plan and/or crisis safety plan), including under what circumstances and what type of intervention is to be used, how and when intervention will be used.

- The child and family team must approve the service plan (wraparound plan and/or crisis safety plan).
- Verbal and written notification to the individual or legally authorized representative must be provided describing the right to discontinue use of the restrictive intervention at any time, and written consent of the individual or legally authorized representative must be documented in the case record.
- Allowance for a revised plan must be made when the restrictive intervention is not working.
- The effects of the intervention in relation to the individual's health and welfare must be considered.
- Each person who is to apply the restrictive intervention must be trained in the proper use at least annually and as the needs of the individual change. The training must be documented in the case record.

At least annually, and when the individual's needs change, the child and family team must review the need for use of the restrictive intervention to determine the effectiveness of the program and the need to continue the restrictive intervention.

- 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:

The State monitors the local mental health authority, local behavioral health authority or the entity providing targeted case management and the waiver provider agencies for use of any restrictive intervention through record review, critical incident reporting, and complaints. Any restrictive intervention requested on the service plan (individual plan of care) requires prior-authorization and approval by the State. The State will require the service plan (wraparound plan and/or crisis safety plan) that describes the need for the restrictive intervention including what type of intervention is to be used, how and when intervention will be used, and what alternative have been attempted.

During annual desk or onsite reviews the State will review and evaluate the use and success of restrictive interventions in ensuring the health, welfare and safety of the participant. The unauthorized use of any restrictive interventions by the local mental health authority, local behavioral health authority or the entity providing targeted case management and the waiver provider agencies will be identified in a formal report and require immediate correction. HHSC analyzes data regarding this assurance through reports presented at Quality Review Team meetings quarterly, and when potentially harmful practices are identified, develop remediation or improvement plans, as needed. In the case of restrictive interventions it is likely that the remediation plans will involve communication and other technical assistance to waiver provider agencies about issues and trends identified through the quality process.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

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

The State prohibits the use of seclusion. In accordance with title 25 of the Texas Administrative Code §414.312 seclusion is prohibited in community settings.

HHSC has a client rights hotline that is staffed to investigate any violations or perceived violations of an individual’s rights. The waiver provider agency provides the hotline number to each waiver participant and legally authorized representative. HHSC must investigate all complaints made to the client rights hotline. Suspicion of abuse, neglect, or exploitation in relation to the use of seclusion is reported to the Department of Family and Protective Services for investigation.

Complaints concerning unapproved use of seclusion can be made to HHSC or the Department of Family and Protective Services. The YES provider must assure that an individual or legally authorized representative is informed orally and in writing of the processes for filing complaints about the provision of YES services including:

- The toll-free telephone number of HHSC 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.

HHSC monitors the unapproved use of seclusion through on-site surveys and complaint investigations.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

No. This Appendix is not applicable (do not complete the remaining items)

Yes. This Appendix applies (complete the remaining items)

b. Medication Management and Follow-Up

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

General Residential Operations: The Department of Family and Protective Services is responsible for licensing and regulating General Residential Operations in Texas. The Department of Family and Protective Services staff enforce these rules through regular inspections and investigations at licensed facilities. Every licensed facility receives at least one unannounced inspection annually. Minimum standard rules address a wide variety of requirements, including medication requirements. Medication requirements include consent for giving medications, administration, records, storage, destruction, medication errors, response to side effects and adverse reactions, and regular review of psychotropic medications.

Other YES contracted providers do not provide medication management.

- 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.

General Residential Operations: The Department of Family and Protective Services conducts inspections and monitors the facilities and reviews for compliance with minimum standards and contract requirements related to medications by assessing clinical records, medication logs and other documentation of medication. Identification of harmful practices are reported to the Department of Family and Protective Services and appropriate corrective actions are taken to bring facilities back into compliance. The Department of Family and Protective Services also provides technical assistance on meeting and maintaining standards and achieving quality in child care.

Other waiver providers: HHSC conducts surveys and monitors providers for compliance with licensing requirements. When harmful or non-compliant practices are identified, corrective action is taken to bring the facility back into compliance. HHSC includes medication management review as part of its quarterly risk review of contracted waiver provider agencies.

In accordance with 42 CFR Sec. 431.10 (e), the single State Medicaid Agency retains administrative authority over the waiver program. HHSC is actively involved in the development of, and will provide final approval of, the initial waiver prior to submission to CMS. Amendments, CMS 372 reports, and all state rules for waiver program operations are coordinated with, and approved by, HHSC. Additionally, HHSC is actively involved in the development of the Quality Oversight Plan, which outlines the frequency of each agency's activities. HHSC analyzes data regarding each assurance through reports presented at Quality Review Team meetings no less than quarterly, and when potentially harmful practices are identified, develop remediation or improvement plans, as needed. In the case of medication management, it is likely that the remediation plans will involve communication and other technical assistance to waiver provider agencies about issues and trends identified through the quality process.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

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

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

- ii. State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or

waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

For General Residential Operations: The Department of Family and Protective Services minimum standard rules for residential child care facilities are found Title 40 of the Texas Administrative Code, Part 19, Chapters 748 and 749. Minimum standard rules address a wide variety of requirements, including medication requirements. Medication requirements include consent for giving medications, administration, records, storage, destruction, medication errors, response to side effects and adverse reactions, and regular review of psychotropic medications.

If a nurse or physician delegates medication management to unlicensed staff it must be documented in the waiver participant's case file. HHSC monitors, through annual on-site or desk reviews and waiver provider agency self-reporting, to ensure that unlicensed staff receive training regarding the delegation of medication from the delegating medical professional. The provider must implement written procedures to ensure safe medication service delivery including medication delegation.

For other waiver providers:

The direct service provider must be qualified under the scope of their licensure to administer medications. The parent or legally authorized representative must sign an authorization for the direct service provider to administer each medication according to label directions.

The medication must be in the original container labeled with the waiver participant's full name and expiration date.

The direct service provider must administer the medication according to the label directions or as amended by a physician.

The direct service provider must administer the medication only to the waiver participant for whom it is intended.

The direct service provider must not administer the medication after its expiration date.

The direct service provider may provide non-prescription medications if the waiver provider agency obtains consent from the parent or legally authorized representative prior to administration of the medication. Consent may be given over the phone and documented as such by the respite provider.

The direct service provider must document the following:

- Full name of the waiver participant to whom the medication was given,
- Name of the medication,
- Date, time, and amount of medication given, and
- Full name of individual provider administering the medication.

All medication records must be kept for three months after administering the medication.

All medications must be stored as follows:

- Out of reach of children or in locked storage
- In a manner that does not contaminate food
- Refrigerate if require and kept separate from food

Unused prescription medications are to be returned to the parent or legally authorized representative.

Self-administration of medications may occur under the supervision of a direct service provider. The provider must ensure:

The parent or legally authorized representative has signed an authorization for the waiver participant to self-administer each medication according to label directions.

The medication must be in the original container labeled with the waiver participant's full name and expiration date.

The waiver participant administers the medication in amounts according to the label directions or as amended by a physician.

The waiver participant must administer the medication only to him or herself.

The waiver participant must not administer the medication after its expiration date.

The waiver participant may provide self-administer non-prescription medications if the direct service provider obtains consent from the parent or legally authorized representative prior to the self-administration of the medication. Consent may be given over the phone and documented as such by the respite provider.

The direct service provider must document the following:

- Full name of the waiver participant who self-administered the medication,
- Name of the medication,
- Date, time, and amount of medication given, and
- Full name of waiver provider supervising the self-administration of the medication

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

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

HHSC

(b) Specify the types of medication errors that providers are required to *record*:

YES waiver providers are required to record the following types of medication errors: Medication given to the wrong waiver participant, giving the waiver participant the wrong medication, giving the incorrect dosage, failing to give the medication at the correct time, failing to use the correct route, or failing to accurately document the administration of the medication.

(c) Specify the types of medication errors that providers must *report* to the state:

YES waiver providers are required to report the following medication errors to HHSC: Medication given to the wrong waiver participant, giving the waiver participant the wrong medication, giving the incorrect dosage, failing to give the medication at the correct time, failing to use the correct route, or failing to accurately document the administration of the medication. All medication errors are reported as critical incidents by the waiver provider agencies.

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.

General Residential Operations: The Department of Family and Protective Services is responsible for monitoring the performance of providers administering medications to waiver participants. The Department of Family and Protective Services staff enforce requirements through regular inspections and investigations at licensed facilities. Every licensed facility receives at least one unannounced inspection annually.

Other waiver providers: HHSC is responsible for monitoring the performance of providers administering medications to waiver participants. HHSC conducts annual on-site or desk reviews of all waiver provider agencies. These reviews include medication management and administration. If the review identifies any issues, HHSC completes follow-up remediation in accordance with each waiver provider agencies' corrective action plan.

HHSC staff enforce requirements through quarterly risk assessment and review of critical incidents. The waiver provider agencies are responsible for reporting medication errors to HHSC through the critical incident reporting process. Medication errors are monitored through the HHSC quarterly risk assessment process. The waiver program requires the submission of the Critical Incident Reporting form by the waiver provider agencies within 72 hours of a medication management incident.

In accordance with 42 CFR Sec. 431.10 (e), the single State Medicaid Agency retains administrative authority over the waiver program. HHSC is actively involved in development of, and provides final approval of, the waiver activities prior to submission to CMS. Subsequent amendments, CMS 372 reports and all state rules for waiver program operations are coordinated with and approved by HHSC. Additionally, HHSC is actively involved in the development of the Quality Oversight Plan, which outlines the frequency of each agency's activities. HHSC analyzes data regarding each assurance through reports presented at Quality Review Team meetings quarterly, and when potentially harmful practices are identified, develop remediation or improvement plans, as needed. In the case of medication management, it is likely that the remediation plans will involve communication and other technical assistance to waiver provider agencies about issues and trends identified through the quality process.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.** (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

G.a.3. Number and percent of waiver participants critical incidents in which waiver provider agencies followed the required process for responding to critical incidents.

N: Number of waiver participants critical incidents in which waiver provider agencies followed required process for responding to critical incidents. D: Number of critical incidents found in reviewed participants' records.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Onsite and desk record reviews

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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = Confidence interval: +/-5 Confidence level: 95%
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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

Performance Measure:

G.a.1. Number and percent of waiver participants who received information on how to report abuse, neglect, or exploitation. N: Number of waiver participants who received information on how to report abuse, neglect, or exploitation. D: Number of waiver participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and Desk Record Reviews

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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		Confidence interval: +/-5 Confidence level: 95%
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

G.a.2. Number and percent of waiver participants or legally authorized

representative informed orally and in writing of the process for filing complaints. N: Number of waiver participants or legally authorized representative that were informed orally and in writing of the process for filing complaints. D: Number of waiver participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site and Desk Record Reviews

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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;"> Confidence interval: +/-5 Confidence level: 95% </div>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	

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

Performance Measure:

G.a.4 Number and percent of direct service providers trained in the requirements to report allegations, acts constituting, and methods to prevent abuse, neglect, or exploitation. N: Number of direct service providers trained in the requirements to report allegations, acts constituting, and methods to prevent abuse, neglect, or exploitation. D: Number of direct service providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Review On-site or Desk Review

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

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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

Performance Measure:

G.a.5 Number and percent of provider reported critical incidents (including abuse, neglect, or exploitation, and unexplained death) for which providers acted appropriately to ensure the health and safety of the individual. N: Number of provider reported critical incidents for which providers acted appropriately. D: Number of provider reported critical incidents.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Critical Incident Records Department of Family and Protective Services database and Investigation Reports Waiver Provider personnel records

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

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>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

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>):
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

b. Sub-assurance: *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

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

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

Performance Measure:

G.b.1. Number and percent of abuse, neglect, exploitation, and unexplained death investigations where the State adhered to the follow-up methods to ensure resolution and prevention of similar incidents. N: Number of investigative reports where the State adhered to the specified follow-up methods. D: Number of investigative reports received.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Onsite and desk record review

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

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

Data Aggregation and Analysis:

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

c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measures

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

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

Performance Measure:

G.c.1 Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver. N: Number of restraint applications, seclusions or other restrictive interventions that followed procedures as specified in the waiver. D: Total number of restraint applications, seclusions or other restrictive interventions.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Onsite and desk record review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> Confidence interval: +/-5 Confidence level: 95% </div>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify:

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

Data Aggregation and Analysis:

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

d. Sub-assurance: *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

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

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

Performance Measure:

G.d.1 Number and percent of waiver participants who received a mental health

assessment prior to receiving services. N: Number of waiver participants who received a mental health assessment prior to receiving services. D: Number of waiver participants enrolled during the review period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Onsite and Desk Record Reviews

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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = Confidence Interval = +/-5 Confidence Level = 95%
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="405 577 798 658" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="868 864 1260 945" type="text"/>

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

HHSC is responsible for overseeing the reporting of and response to critical incidents that affect waiver participants.

HHSC Participant Rights Notification form is explained orally by the waiver provider agency case manager to the waiver participant and his or her legally authorized representative. This explanation occurs prior to the waiver participant or legally authorized representative and case manager signing this form. The case manager explains the complaint procedures including a 24-hour, 7 days a week toll-free number and website information for reporting any allegation of abuse, neglect, or exploitation to the Department of Family and Protective Services. The case manager explains the documented process for contacting HHSC Office of Consumer Services and Rights Protection to register a complaint or report an incident, and the HHSC Office of the Ombudsman's telephone number if the waiver participant has problems or complaints about a state agency health and human agency service or program. All waiver participants and legally authorized representatives acknowledge receipt of the HHSC Handbook of Consumer Rights, and Mental Health Services. Information is provided by the case manager orally regarding how to request a Medicaid fair hearing, which is also provided in the handbook.

The waiver requires a review of each waiver participant's service plan (individual plan of care) every 90 days, and recommends monthly wraparound team meetings in order to ensure that the waiver participant's safety and crisis plans continue to be effective. The case manager is responsible for determining if any existing situations that may jeopardize the waiver participant's health and welfare. Revisions to the safety and crisis plans may be made at any time by the wraparound team or the case manager to ensure the health and safety of the waiver participant. If there is a revision to the service plan, it must be submitted to HHSC for approval with reasons for the change documented. The case manager must document in the individual's clinical record that the plan was effective or that revisions were required.

Waiver provider agencies must develop, implement, and enforce a written policy that includes, at a minimum, HHSC child abuse screening, documenting, and reporting policy for contractors/providers and train all direct service staff on reporting requirements.

An allegation of abuse, neglect, or exploitation must be reported to the Department of Family and Protective Services immediately and within one business day after the allegation, a Client Abuse and Neglect Reporting form is submitted to the Department of Family and Protective Services. The waiver provider agency must report allegations of abuse, neglect, and exploitation to the HHSC waiver program staff within 72 hours of the incident. This documentation at a minimum includes date of contact, the name of the individual on whose behalf the report is being made, a brief synopsis of allegations, and the name of the Department of Family and Protective Services employee taking the report. The Department of Family and Protective Services sends provider agencies copies of each investigation outcome involving an individual enrolled in the Youth Empowerment Services waiver. The waiver provider agency must retain reporting documentation on site and make it available for inspection by HHSC when requested.

All contacts related to reporting of suspected abuse, neglect and exploitation must be documented by all direct service staff. This documentation, at a minimum, shall include date of contact, the name of the waiver participant on whose behalf the report is being made, a brief synopsis of allegations, and the name of the Department of Family Protective Services employee taking the report.

Critical incidents related to abuse, neglect, and exploitation are also reported to Child Protective Services at the Department of Family and Protective Services if a parent is involved. These incidents are reported to law enforcement if the alleged perpetrator is not a parent. If the incident is an emergency or life-threatening situation it must be reported to local law enforcement immediately.

Depending on the severity of the allegation,

Department of Family and Protective Services investigations must be completed within 14 to 21 days. Investigation results are provided to the participant or legally authorized representative in writing no later than 15 days after the investigation is closed by the supervisor.

The director of the waiver provider agency, local mental health authority, local behavioral health authority or and the entity providing targeted case management may not change a confirmed finding made by a Department of Family and Protective Services investigator. The director may request a review of the finding or the methodology used to conduct the investigation.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

If the State discovers that a waiver participant or legally authorized representative was not informed of how to report allegations of abuse, neglect, or exploitation or other complaints, the waiver provider agency is required to provide the waiver participant or legally authorized representative with appropriate educational material. The waiver provider agency may also be subject to various remedies which may include communicating with the waiver provider agency directly and requiring corrective actions to be completed when appropriate.

If the State discovers that waiver provider agencies have not followed the contractually required process for reporting and responding to critical incidents, the waiver provider agency is subject to various remedies which may include HHSC communicating with the waiver provider agency, requiring corrective actions to be completed when appropriate, freezing enrollment into the waiver provider agency, and termination of the waiver provider agency's contract. If a corrective action is required, HHSC will monitor the waiver provider agency less than quarterly to ensure change in system occurs. All remedies are accompanied by the requirement that the waiver provider agency will resolve the complaint.

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>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="317 1249 743 1332" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="815 1563 1241 1646" type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

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.

YES waiver system improvement begins with the collection and analysis of data on system performance. YES Waiver staff utilizes a quality oversight plan that describes how quality indicators are tracked and reported on a quarterly basis. The YES 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 data analytic, policy, data collection, program implementation, and managerial staff within HHSC, reviews YES data to establish priorities and directs the improvement activities for the waiver. The Quality Review Team (QRT) oversees implementation of the quality oversight plan and related processes. QRT members collectively designate staff to make recommendations for new or revised quality measures, identify and facilitate access to new data sources, identify new processes impacting any and all phases of the quality program, and perform other actions needed to assure continued improvement of YES waiver program.

Designated YES Waiver quality review team and managerial, or other support staff engage in quality workgroup meetings as needed to implement improvements. Documentation of meetings is maintained so that there is an ongoing history of discussions, ideas, proposed interventions, and evaluations of attempted system improvements implemented.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: <input type="text"/>	Other Specify: <input type="text"/>

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 quarterly and annual reports include data for all of the waiver’s quality improvement strategy measures, along with applicable remediation activities and outcomes. HHSC present the reports and recommendations for system improvements to the Quality Review Team, which establishes priorities for quality improvement initiatives. 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 need for other internal and external stakeholder involvement will be collaboratively assessed by the performance management specialist, Quality Review Team, data and program liaisons during all phases of performance measure development data collection and reporting. External stakeholders, are engaged through stakeholder meetings, data shared on our website and community presentations.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

HHSC 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 will examine issues such as whether or not the indicators are providing substantive information about each subassurace; 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 H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

- b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

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).

The waiver program staff conduct annual on-site or desk reviews of the waiver provider agencies. During these reviews, HHSC staff compares the approved and billed services to the services documented in the individual's case record. HHSC staff reviews a sample of service plans to verify that financial eligibility has been met and that any applicable service and cost limitations have not been exceeded.

For both local mental health authorities and other waiver providers, all contract records and documents are subject to examination and audit by the Comptroller of Public Accounts, the State Auditor's Office, HHS Internal Audit, the Office of Inspector General, Contract Oversight and Support, and other state and federal auditors..

*Only those costs allowable under Texas' Uniform Grants Management Standards (UGMS) are allowable costs under the waiver. Applicable cost principles, audit requirements, and administrative requirements include:
Applicable Cost Principles - OMB Circular A-87, State, Local & Tribal Governments Audit Requirements - OMB Circular A-133 and UGMS
Administrative Requirements - UGMS.*

The State enrolls waiver providers through an open enrollment process. To apply to be considered for enrollment, an applicant must provide an independent financial statement audit if the organization has not undergone a financial audit within the last two years, financial statements for the last completed fiscal year.

The State captures claims data using a state-developed software application, Clinical Management for Behavioral Health Services (CMBHS). The State analyzes claims data for anomalous data points, which are used for reviews. During on-site and desk reviews, HHSC samples documentation that correlates with claims data to verify the provider rendered billed services. The State verifies financial eligibility via CMBHS before services are rendered and validates financial eligibility again when a claim is submitted to HHSC's agent, Texas Medicaid and Healthcare Partnership (TMHP), for payment. TMHP does not reimburse for services provided to individuals who are not financially eligible. CMBHS has system edits in place that prevent individual cost limits from being exceeded for services rendered, and HHSC reviews all plans of care to ensure authorized services are below the individual cost ceiling.

The Office of the Inspector General (OIG) reviews and collects substantiated overpayments and sanctions that can be pursued in a case. The OIG also receives referrals regarding provider overpayments and penalties from the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU).

How recoupment of funds are processed depends on the source of the repayment to the State and the form of the repayment to the State. The source of the overpayment can be either a client, provider, or managed care organization. The form of the repayment from clients and providers can be either through a cash payment or an offset of providers' future claim payments, or a reduction of future payments to clients. If the funds are received through a cash payment, the OIG receives the payment and sends it to HHSC Accounts Receivable. If funds are recovered through offsets to a provider's future fee-for-service claim payments, the OIG will instruct Texas's Medicaid Claims Administrator to recoup the overpayment from the provider's future claim payments. For clients, HHSC Accounts Receivable will work to establish a payment agreement to recoup funds. Texas can also collect delinquent recoveries through lottery offsets and suspend drivers licenses.

HHSC is responsible for federal reporting and calculating federal funds that are returned based on overpayment recoveries. HHSC reports the federal portion of the recoveries/overpayments along with other program expenses and revenues. All Medicaid reimbursements are split according to the Federal Medical Assistance Percentages (FMAP) rates. The FMAP rate applied at the time of recovery depends on the claim type determination of either "claim specific" or "non-claim specific." For claim specific recoveries, where a specific claim is adjusted, the federal share is determined by the FMAP rate paid for the specific date of service. The current year FMAP rate is used to determine the federal share of non-claim specific recoveries where the original payment date and rate cannot be determined, usually due to a settlement. Medicaid recoveries are reported to the federal government through the Centers for Medicare and Medicaid Services (CMS) 64 report. Recoveries are returned to the program to provide benefits to other clients. Inappropriate billings and overpayments are removed from the State's federal financial participation (FFP) calculation as recoveries are made. If the overpayment has not been returned to the State in the form of either a cash payment or through offsets within 365 days, HHSC will front the return of the federal share to CMS with state funds. HHSC runs a weekly 150(c) report to ensure HHSC removes all inappropriate billings from the FFP calculation. HHSC will then continue in its efforts to recoup any outstanding overpayments from the client or provider.

HHSC requires all providers with a compliance score below 90 percent to submit a plan of correction within 30 business days after receiving the HHSC quality management report. HHSC reviews and approves the plan of correction, or if HHSC needs additional details, will request revisions before approving the plan of correction. HHSC may continue to monitor and

require evidence of corrections from waiver providers to ensure the providers completed the prescribed corrective actions.

All waiver provider agencies receive a claims audit as part of their annual on-site or desk review. Before conducting a provider agency review, the State analyzes all claims data by service type, direct service provider, and participant for over- and underutilization of services. The sampling method includes both random selections and records reviewed to examine specific variables, such as numbers of members served, types and amount of services rendered, and numbers of private providers. HHSC compares service claims to a waiver participant's service plan (individual plan of care) to ensure that the services a waiver provider agency provides are consistent with authorized services and meet service definitions. Providers are required to repay any identified overpayment or service claims that did not meet requirements.

The State reviews claims for the entire waiver year— April 1 through March 31.

The State annually reviews 100 percent of provider agencies.

Waiver program staff refer suspected FWA cases to the OIG through the OIG's centralized intake. Program staff may submit suspected FWA through the OIG's FWA online reporting form or may call the OIG's toll-free hotline. Program staff may also report suspected FWA by sending an email directly to the OIG General Inquiries email address. The identity of the program employee who submitted the referral and any information the employee provides is kept confidential to the extent permitted by law, pursuant to Texas Government Code §531.102(k), §531.1021(g), and pertinent privacy laws. If the OIG investigator finds criminal activity in relation to the referred FWA case, the investigator refers the complaint to the Attorney General's Medicaid Fraud Control Unit (AG-MFCU). Alternatively, waiver program staff may report suspected Medicaid provider and recipient fraud directly to the AG-MFCU by phone, sending an email, or by mailing a written letter.

The primary tools used to detect fraudulent billing activities are audits (conducted using the federal "Yellow Book" standard); investigations (conducted in accordance with generally accepted investigative policies); and inspections (conducted using the federal "Silver Book" standard). The OIG identifies fraudulent billing activities by performing risk-based performance, provider, and information technology audits related to (a) the accuracy of medical provider payments; (b) the performance of Health and Human Services (HHS) agency contractors; and (c) programs, functions, processes, and systems within the HHS System. The OIG also identifies fraudulent billing activity by investigating employee misconduct, contract and recipient fraud, waste, and abuse and by analyzing data to identify trends and patterns of behavior. The OIG conducts claims and medical record reviews on a variety of HHSC programs. Some fraudulent billing activities are identified in referrals that come through the OIG Integrity Line or complaints from the OIG's online Waste, Abuse, and Fraud Electronic Referral System.

To ensure that providers address fraudulent activities, the OIG will take initial actions related to terminating or excluding providers when required by federal law. The OIG handles the appeal of investigations and audits that have determined providers have received Medicaid funds to which they were not entitled. These investigation cases are settled by agreement or resolved by trial before a State Office of Administrative Hearings Judge. Audit files are settled by agreement or resolved by trial before an HHSC-Appeals Judge. The OIG will refer cases for Administrative Disqualification Hearings and prosecution to appropriate state or federal regulatory and law enforcement authorities. The OIG makes referrals to the Office of the Attorney General's MFCU when criminal Medicaid fraud indicators are present. The Office of the Attorney General's MFCU investigates criminal and civil fraud by Medicaid providers and prosecutes criminal fraud or assists local and federal authorities with prosecutions. The OIG and the Office of the Attorney General's MFCU work together on joint investigations by sharing resources and information that will lead to successful administrative or criminal prosecution.

The on-site and desk reviews do not differ in terms of the method, scope, or sample size. Each year, HHSC selects and reviews a representative sample of direct service providers from each waiver provider agency annually. The on-site and desk reviews both include a review of provider credentials, training, and criminal history checks. During on-site reviews, HHSC has access to the direct service providers personnel and training records. For desk reviews, HHSC reviews electronic copies of direct service providers personnel and training records.

All waiver provider agencies receive an HHSC claims audit as part of their annual on-site or desk review. Before conducting a provider agency review, HHSC analyzes all claims data for over and underutilization of services by service type, direct service provider, and participant. The sampling method includes both random selections and records reviewed to examine specific variables, such as numbers of members served, types and amount of services rendered, and numbers of private providers. HHSC selects a representative sample size of direct service providers from each provider agency with a confidence level of 95 percent and a margin of error of 5 percent. To comply with §1903(l) of the Social Security Act, as added by the 21st Century Cures Act, HHSC is requiring YES program providers to use electronic visit verification (EVV) for in-home respite. The use of EVV is enforced through an automated matching process which compares an accepted EVV

visit transaction to a program provider’s service EVV claim before the payment of the EVV claim. If critical data elements on the EVV visit transaction and EVV claim do not match, the EVV claim is denied.

HHSC EVV Operations will also assess program provider compliance with EVV requirements through EVV compliance reviews. EVV compliance reviews will begin one year after Dec. 1, 2020. Program providers who fail to comply with EVV requirements based on a compliance review may be subject to contract action by HHSC, including recoupment.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

I.a.1. Number and percent of claims that were paid in accordance with the state's reimbursement methodology. N: Number of claims that were paid in accordance with the state's reimbursement methodology. D: Number of claims.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Clinical Management for Behavioral Health Services (CMBHS) database

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

		Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

I.3. Number and percent of service encounters billed at approved rates. N: Number and percent of service encounters billed at approved rates. D: Number of encounters billed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Clinical Management for Behavioral Health Services (CMBHS) database

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

Data Aggregation and Analysis:

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

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

Performance Measure:

I.a.2. Number and percent of waiver service claims reviewed that were submitted for participants who were enrolled in the waiver the date the service was delivered. N: Number of waiver service claims reviewed that were submitted for participants who were enrolled in the waiver the date the service was delivered. D: Number of service claims.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Clinical Management for Behavioral Health Services (CMBHS) 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):
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <input type="text"/>
<i>Other</i> <i>Specify:</i> <input type="text"/>	<i>Annually</i>	<i>Stratified</i> <i>Describe Group:</i> <input type="text"/>

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

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:

I.b.1 Number and percent of provider payment rates that were consistent with the rate methodology in the approved waiver. N: Number of provider payment rates that were consistent with the rate methodology in the approved waiver. D: Number of provider payment rates.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Health and Human Services Commission Rate Analysis Department

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

Data Aggregation and Analysis:

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

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

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

HHSC contracts with waiver provider agencies to deliver services across Texas.

Local mental health authorities and local behavioral health authorities are entities that are required to have annual independent audits by external qualified firms to ensure fiduciary compliance, propriety of and support for fund expenditures, and accurate and timely reconciliation of fund balances. Verification of internal controls is an integral part of the audits. At the time of open enrollment, other waiver providers are required to submit to HHSC a copy of the most recent independent audit, or provide financial reports to include a current balance sheet, statement of revenue and expenditures, and a statement of cash flow.

HHSC Contract Oversight Unit reviews local mental health authorities, local behavioral health authorities, entities providing targeted case management and waiver provider agencies financial statements. HHSC conducts risk assessments to identify problems with service utilization and billing. Desk or onsite reviews are conducted to evaluate billing and internal controls. The HHSC Internal Audit Division reviews existing contract monitoring processes to determine whether monitoring efforts ensure funds are utilized appropriately and local mental health authorities are meeting performance expectations.

Providers are contractually required to submit claims to the Texas Medicaid and Healthcare Partnership (TMHP) via the state provided Software as a Service (SaaS) tool; Clinical Management for Behavioral Health Services (CMBHS). HHSC personnel analyze claims data associated with local mental health authorities, local behavioral health authorities, entities providing targeted case management and waiver provider agencies analyze service utilization and to identify any anomalies. HHSC's annual on-site or desk review of the waiver provider agencies compares a sample of a provider's paid service claims to the services documented in the individual's case record. The waiver provider agency is required to maintain documentation of services provided in the individual's clinical record. HHSC may access the individual's clinical record at any time to compare service claims with documentation of service provision. Providers are required to repay any identified overpayment or service claims that did not meet requirements.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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. The options for remediation are listed below:

If HHSC determines that claims were not paid in accordance with the state's reimbursement methodology HHSC takes corrective action within five business days.

If the State discovers that a payment was made to a waiver provider agency for a non-eligible individual or for services that were not in the service plan, the State recoups the funds from the waiver provider agency. At the end of the month in which the waiver participant becomes ineligible, the waiver participant is removed from the program, considered for other available services, and provided with information on how to request a fair hearing.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

No

Yes

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group*

services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Texas Health and Human Services Commission (HHSC), the State Medicaid Agency, determines payment rates at a minimum of every two years. Payment rates are determined for each service. The rates for services are prospective and uniform statewide. HHSC determines payment rates after analysis of financial and statistical information and the effect of the payment rates on achievement of program objectives, including economic conditions and budgetary considerations. The Texas Legislature appropriates funds biennially and rates are adjusted to remain within appropriations.

Texas will use existing service rate methodologies from the CLASS, HCS, DBMD, MDCP and former CBA waivers to set service rates for the YES Waiver. The rates for the YES Waiver are available on the Rate Analysis webpage located at <https://rad.hhs.texas.gov/long-term-services-supports/youth-empowerment-services-waiver-program-yes>. Specifically, the supported employment rate in YES Amendment 4 was modeled after common Supported Employment services in the other HCBS waivers mentioned above. Certain services are common among the different waiver programs, such as nursing, therapies, behavioral support, audiology, speech/language pathology, employment assistance and supported employment. For these common services, the rates are determined by combining the biennial cost report data for those programs into a single array (where sufficient, reliable data exists). The array is weighted by the number of units of service and the median cost per unit of service is calculated. The biennial cost report data includes direct service costs (wages, benefits, contract services), administrative and operations expenses. The rates for these common services are statewide, prospective, non-geographical and are not tiered for difficulty or level of care. While HHSC has adopted a single rate methodology for common services, the adopted rate in a program for a common service may be different than the rate for the same service in other programs due to historical differences in the rate methodologies for different programs. HHSC adjusts the rates for common services to be fully funded per the rate methodology as appropriations become available.

In general, HHSC models the rates for the following services from the other Medicaid HCBS waiver programs that use cost reports to determine rates: respite in the waiver participant's home or place of residence or the private residence of a respite care provider; respite in a foster home verified by a Texas Department of Family and Protective Services (DFPS) licensed child placing agency; respite in a general residential operation licensed by DFPS; respite in a day or overnight camp accredited by the American Camping Association or licensed by DSHS; respite in a child care center or home licensed by DFPS or a child care home registered with DFPS; family supports; paraprofessional services; specialized therapies; and supportive family-based alternatives, supported employment; and employment assistance.

Providers of these services are required to submit biennial cost reports to HHSC. Providers are responsible for eliminating all unallowable expenses from the cost report prior to submission of the cost report. The HHSC Cost Report Review Unit reviews all cost reports and a sample of cost reports are audited on-site. The Cost Report Review Unit removes any unallowable costs and corrects any errors detected on the cost report in the course of the review or on-site audit. Audited cost reports are used in the determination of statewide prospective rates.

In general, recommended unit of service rates for each service are determined as follows: 1) total allowable costs for each provider are determined from the audited cost report; 2) each provider's total allowable costs are projected from the historical cost reporting period to the prospective reimbursement period; 3) payroll taxes and benefits are allocated to each salary item; 4) total projected allowable costs are divided by the number of units of service to determine the projected cost per unit of service; 5) the allowable costs per unit of service for each contracted provider are arrayed and weighted by the number of units of service and the median cost per unit of service is calculated; and 6) the median cost per unit of service for each waiver service is multiplied by 1.044.

When comparable services do not exist, reimbursement rates are determined using a pro forma approach. This approach involves using historical costs of delivering similar services, where appropriate data are available, and estimating the basic types and costs of products and services necessary to deliver services meeting federal and state requirements to set waiver rates. HHSC models rates as specified below.

Adaptive aids and supports and minor home modification are paid at cost. Providers are given additional payments for the cost of acquiring adaptive aids and supports and minor home modifications for waiver participants; 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.

The rates for community living supports (CLS) are determined by modeling the salary for a Qualified Mental Health Provider-Community Services (QMHP-CS) staff position. This rate is updated periodically for inflation.

Non-medical transportation is paid at the rate set by the Texas Comptroller of Public Accounts.

The rate for transitional services is a one-time payment for the procurement of items and services the waiver participant needs to move from an institution, a provider-operated setting, or family home to the participant's own private community residence. The rate is determined by modeling the estimated salary for a person with the necessary skills and training, and the estimated time spent with the waiver participant and procuring the necessary goods and services. The salary and time estimates were based upon the experience of providers delivering similar services under a different program. This rate is updated periodically for inflation.

HHSC holds a public hearing before it approves rates. The purpose of the hearing is to give interested parties an opportunity to comment on the proposed rates. Notice of the hearing is provided to the public. The notice of the public hearing includes information about the proposed rate changes and identifies the name, address, and telephone number of the staff member to contact for the materials pertinent to the proposed rates. At least ten working days before the public hearing takes place, material pertinent to the proposed statewide uniform rates is made available to the public. The public may present comments at the hearing or submit written comments regarding the proposed rates. Information about payment rates is made available to waiver participants through the HHSC website as well as through the Texas Register via a public notice.

DSHS still exists for certain functions, among them licensing overnight camps in the State of Texas.

Before the State established a single rate methodology for common services, the rates for some of the common services differed across programs as a result of different appropriation levels. The common services that have rates that are different than the single rate for that service may not have been adjusted due to budgetary and other considerations.

HHSC desk reviews all cost reports using criteria specific to the allowable and unallowable costs for each type of cost. Some cost parameters are hard-coded into the cost report system, and the cost-report preparer must correct them before the report can be submitted; for example, a preparer cannot report a salary lower than the federal minimum wage. For allowable cost types that fall within a range, HHSC has set parameters for the costs. If a cost report preparer reports a cost outside of the pre-defined parameter, the preparer is required to explain why the cost is outside the parameter. The State reviews the preparer's explanation for appropriateness, and the Cost Report Review Unit (CRRU) Auditors contact the provider and/or preparer to obtain further information for those costs that are outside of the parameters that do not have a sufficient explanation. The CRRU Auditor may ask for documentation to support the explanation if the auditor deems it appropriate. If the provider or cost-report preparer is unable to provide sufficient explanation or documentation, the CRRU Auditor refers the matter to the Rate Analysts for further investigation.

The rates are calculated as the median rate; the 4.4 percent increase above the median rate brings the rate to approximately the 60th percentile. This allows for the costs of a larger number of providers to be covered by the rate while still setting rates that are economical and efficient.

The cost report instructions are on the HHSC website at:

<https://rad.hhs.texas.gov/long-term-services-supports/2017-cost-report-information/2017-cost-report-program-specific>

The allowable and unallowable costs are detailed in the Texas Administrative Code: Title 1, Part 15, Chapter 355, Subchapter A, §355.102 (relating to General Principles of Allowable and Unallowable Costs) and Title 1, Part 15, Chapter 355, Subchapter A, §355.103 (relating to Specifications for Allowable and Unallowable Costs). Both may be found at the following link:

[http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=5&ti=1&pt=15&ch=355&sch=A&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=1&pt=15&ch=355&sch=A&rl=Y)

The State modeled the salary for the Qualified Mental Health Provider-Community services staff using data reported by the local mental health authorities and data from the US Department of Labor Bureau of Labor Statistics. The data is updated biennially, and the rates are adjusted as appropriate within appropriations.

HHSC initiated a pilot for Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IIDs), Home and Community-based Services (HCS TX.0110) and Texas Home Living (TxHmL TX.0403)

providers that transitioned their Medicaid Cost Reports from an annual basis to a biennial basis. The pilot was successful in that it reduced the administrative burden on these providers and HHSC staff. Therefore, the HHSC Executive Commissioner extended the program to transition all Long-Term Services and Supports programs that currently submit annual cost reports to a biennial basis beginning with the 2019 cost report.

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:

Provider billings will flow directly from providers to HHSC and will not be routed through intermediaries. HHSC will review the billings in relation to waiver requirements and authorize payment through the state's accounting system.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

[Empty text box for State Public Agencies]

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.)

[Empty text box for Local Government Agencies]

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:

Clinical Management for Behavioral Health Services (CMBHS) is a web-based clinical record keeping system for state-contracted community mental health service providers.

In addition to an electronic health record, CMBHS serves as a clinical tool that includes diagnostic and treatment plan capabilities. CMBHS supports data exchange across contracted substance abuse service providers and between HHSC and other state agencies to coordinate care. The CMBHS system combines the electronic health recordkeeping requirements for both mental health and substance abuse treatment providers in a single system.

CMBHS collects and reviews information about waiver clients, including service plan, level of care, and eligibility information. YES waiver provider agencies submit claims to CMBHS. CMBHS checks the claim information against the service authorization and eligibility information, and sends all claims information to Texas Medicaid and Healthcare Partnership (TMHP) for loading into MMIS and for federal reporting purposes. Texas Medicaid and Healthcare Partnership is a state-contracted Medicaid claims system. CMBHS stores TMHP service authorizations, and interfaces with the TMHP system to process payments to Waiver Providers.

The providers enter service notes into CMBHS. CMBHS automated system edits to verify service notes contain all required information and that the amount requested is within expected parameters and authorized level of service. Any anomalies are returned to the provider unpaid, until the issue is resolved. CMBHS system edits include (a) verifying the waiver participant's eligibility for waiver services on the date of service delivery. Waiver services provided outside of waiver eligibility are not submitted to TMHP for reimbursement; (b) verification that services are on the approved plan of care and the plan is within the limits of the waiver. Services that are not on the plan of care and or exceed the limits approved by HHSC are not reimbursed. HHSC's annual review of the waiver provider agency compares the billed services to the services documented in the waiver participant's case record. HHSC also conducts interviews with some of the waiver participants to verify satisfaction with waiver services and verify the delivery of services."

- e. Billing and Claims Record Maintenance Requirement.** *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (select one):**

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or

enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for

expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

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.

This waiver is a part of a concurrent ?1115/?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 ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.

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:

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:

[Empty rectangular box]

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:

Individuals in the YES waiver live in their own homes. Payment of the cost of room and board is the responsibility of the individual except when the individual is receiving out-of-home respite services under the waiver. Room and board is included in the rate for out-of-home respite services.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

[Empty rectangular box]

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

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

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)****a. Co-Payment Requirements.****ii. Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)****a. Co-Payment Requirements.****iii. Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)****a. Co-Payment Requirements.****iv. Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)**

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

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

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital

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	4393.92	9390.73	13784.65	32634.01	38020.02	70654.03	56869.38
2	4487.04	9606.72	14093.76	33319.33	38894.48	72213.81	58120.05
3	4581.31	9837.28	14418.59	34019.03	39827.95	73846.98	59428.39
4	4678.38	10073.38	14751.76	34733.43	40783.82	75517.25	60765.49
5	4774.10	10325.21	15099.31	35462.83	41803.42	77266.25	62166.94

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Hospital	
Year 1	2878		2878
Year 2	3144		3144
Year 3	3325		3325
Year 4	3455		3455
Year 5	3591		3591

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The estimates for Yes Waiver renewal years 1-5 are based on the average length of stay for waiver participants during Waiver Year 2017. It is assumed that length of stay will remain consistent and will not increase or decrease as a result of any of the expected changes to the waiver.

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 and methodology for these estimates is as follows:

*Factor D represents the cost per Yes waiver participant in a particular year. Yes WY 2017 was used as the base year to calculate cost estimates projections for waiver renewal years 1-5. Factor D for 2017 was calculated by dividing total YES services expenditures in 2017 by the number of unduplicated YES participants in 2017, $D_{2017} = \text{total expenditures} / \text{unduplicated participants}$. Factor D_{2017} was then used to calculate waiver renewal estimate for years 1-5. The 2016 Personal Consumption Expenditures (PCE) Deflator was used to calculate a yearly inflation factor that was applied to the calculation. The estimate for Year 1 renewal Factor D_1 , was calculated as $D_1 = D_{2017} * PCE_1$. Years 2 to 5 were calculated in the same manner: $D_2 = D_1 * PCE_2$, $D_3 = D_2 * PCE_3$ etc., etc.*

The Factor D estimates for WYs 4 and 5 are based on claims payment data from September 1, 2010, through December 31, 2015, and current rates (effective September 2013). An assumed annual inflation rate of 5% was added to the current rates.

In September 2014, a new database system, Clinical Management for Behavioral Health Services, was rolled out and provides more accurate and detailed-level client and expenditure information. A thorough analysis was conducted on historical data from September 2014 through December 2015.

The analysis is built at the monthly utilization level. Average monthly utilization data is more reliable/stable than using unduplicated counts for a given year. The costs are derived based on the rates (cost/unit) times the total number of units. Users are derived at the average monthly level and total units are derived by using the monthly units/user times the monthly number of users. The unduplicated counts are then backed into using unduplicated to average monthly ratios based on historical data. This figure is influenced by utilization changes/assumptions. Two major factors in the analysis mentioned below (inflation and rate (cost/unit) increase, inclusion of foster children) are part of the reasons for these shifts.

The State has included inflation and rate (cost/unit) increase factors for future WYs. This accounts for part of the increases to the cost per unduplicated user. Also assumed in the utilization assumption is an increase due to the inclusion of foster children as these kids are potentially higher utilizers than the current YES population.

The YES Waiver was initially implemented as a pilot program including three counties. In 2013, the 83rd Legislature directed the YES Waiver to expand statewide. CMS approved this expansion effective September 2015. As of April 2016, the program is operating at full participation. The number of children served has increased from 400 participants to 1,988, resulting in an increase in the demand for services overall as well as changes to case mix/utilization. The number of users has increased in every category except supported employment and employment assistance. The length of stay in the waiver has also increased from 146 days to 278 days. In the area of respite care the number of users has increased in every category and the number of units per user has also increased, resulting in an increase in the cost per user. All these factors are major contributors to the differences in cost compared to the previous waiver period.

The State expects average Units per Client by Service Type to increase from or stay at the same level as WY17. This is because the expansion in WY16 likely caused units per client to be artificially low due to a lag associated with the expansion of services to new clients and the time it takes for those clients to begin utilizing the units of service.

While the State developed a Standard to estimate future year average units per utilizer, the State evaluated each service on a case-by-case basis to determine if the Standard needed to be altered.

The Standard for projecting the average monthly units per client by Service Type is to use the higher of the WY17 Annual Weighted Average or the average of the WY16 and WY17 Weighted Average.

This Standard was based on an assumption that as the program stabilizes post-expansion, the State expects units per client (1) to be at least as much as WY17 if units per client increased from WY16 to WY17 or (2) to regress to the two-year mean if units per client that decreased from WY16 to WY17.

There are a few exceptions to this Standard, where the State applied a growth trend based on Program and Forecaster Assumptions:

Community Living Supports (CLS): Based on discussions with Program, the State assumed that the 29% drop in WY17 was primarily because, when a program expands, it may take a while for new clients to utilize all services. Typically, after a lag period, the units per client increases. However, the State also assumes that part of the decrease was not due to expansion and was a natural leveling to appropriate CLS units per client. Therefore, the average of WY16 and WY17 of 34.6 would have been too large of an increase from WY17 (20%), and the State applied the assumed 5% trend.

Paraprofessional Services: Based on discussions with Program, the State assumed that the 15% drop in WY17 was primarily due to lags in service utilization that typically occurs when a program is expanded to new clients. The State assumes the units per client will increase. However, similar to CLS, the State assumes part of the decrease was due to natural leveling and therefore determined that the average of WY16 and WY17 of 32 would have been too large of an increase from WY17 (9%), and the State applied the assumed 5% trend.

Specialized Therapies: Based on discussions with Program, the State assumed that the 24% drop in WY17 was primarily due to lags in service utilization that typically occurs when a program is expanded to new clients. The State assumes the units per client will increase. However, similar to CLS and Paraprofessional Services, the State assumes part of the decrease was due to natural leveling and therefore the State also determined that the average of WY16 and WY17 of 36 would have been too large of an increase from WY17 (16%) and the State applied the 5% trend.

Family Supports special note: Although the State used the standard formula for Family Supports, it has been noted that the resulting trend is 18.5%, which is significantly higher than the rest of the WY18 projected annual trends for Units per Client. Based on discussions with Program, the State assumed that the 27% drop in WY17 was primarily due to lags in service utilization that typically occurs when a program is expanded to new clients. The State assumes the units per client will increase. Through discussions specific to Family Supports, the State determined that the average of WY16 and WY17 of 10.97 was more likely of an outcome for WY18—even though that is an increase of 18.5% rather than the assumed 5% trend.

It is also important to note that while all unit per client estimates are increases in WY18 over WY17, they are held at these levels and not trended higher in WY projections post WY18.

Annual Ratios of Unduplicated Utilizers by Service Type to Unduplicated Utilizers across all Service Types.

A Standard for projecting the WY18 through WY23 Ratios was developed based on the following criteria:

Due to Expansion in the 2nd half of WY16, WY16 Ratios were mostly ignored for future projections.

If WY17 average Annual Utilizer Ratio by Service was higher than WY15, WY17 was held flat.

If WY17 average Annual Utilizer Ratio by Service was lower than WY15, a 2.5% standard growth trend was applied (CLS and Specialized Therapies).

WY19 through WY23 Ratios will match WY18 Ratios.

This Standard criteria was based on two assumptions:

(1) The annual Unduplicated Ratios for most utilization types stabilized in WY17 because the State expansion occurred in WY16 and (2) the Annual unduplicated ratio counts every child that showed up at least once for all of WY17 YTD.

For Utilizer Ratios that were lower in WY17 than WY15 and WY16, the State anticipates a regression towards the WY16/17 average but not at a growth level as high as the actual average would produce. A review of the Annual Utilizer Ratios for WY17 as compared to the average of WY15–WY17 show that all ratios were either an increase above the three-year average—as expected—or that the WY17 decline was within 3%. However, there were two exceptions to this, and in those cases the State implemented a 2.5% trend. The two exceptions are expanded upon below:

CLS: WY17 declined by 7.3% in WY17 and was 8.2% below the three-year average including WY17. The State determined that this decline below the three-year average was artificially low and therefore implemented a 2.5% trend.

Specialized Therapies: WY17 declined by 16.1% in WY17 and was 7.8% below the three-year average including WY17. The State determined this decline below the three-year average was artificially low and therefore implemented a 2.5% trend.

Monthly Ratios of Unduplicated Utilizers by Service Type to Unduplicated Utilizers across all Service Types

The Standard for projecting the average monthly ratio of Utilizers by Service Type is as follows:

If WY17 Ratio was higher than WY15, the formula that chooses the Max between WY17 and the average of WY16/17 was used.

If WY17 was lower than WY15, a 5% growth trend was added on top of WY17 (CLS and Specialized Therapies).

This Standard was based on the State's assumption that monthly utilization ratios in WY17 were artificially low due to the expansion, but WY18 ratios will either (1) be at least as much as WY17 for service types that increased from WY16 to WY17 or (2) will regress to the two-year mean for service types that decreased from WY16 to WY17.

There are a few exceptions to this Standard, where the State implemented a growth trend based on Program and Forecaster Assumptions. These assumptions are expanded upon below:

CLS: Based on discussions with Program, the State assumed that the 9.4% drop in WY17 was primarily due to lags in service utilization that typically occurs when a program is expanded to new clients. Consequently, the State expects the average utilizers per month to move higher and implemented the assumed 5% trend.

Specialized Therapies: Based on discussions with Program, the State assumed that the 24% drop in WY17 was primarily due to lags in service utilization that typically occurs when a program is expanded to new clients. Consequently, the State expects the monthly ratio of utilizers to overall utilizers will move higher. However, the State also assumes some of the decrease was due to natural leveling and determined that the average of WY16

and WY17 of 39% would have been too large of an increase from WY17, and the State therefore implemented the assumed 5% trend.

Respite DFPS Monthly average ratio and Annual Ratios were lower in WY17 than WY15, but the State did not apply a standard 2.5% or 5% annual growth trend. The reason for this is that that the expansion specific to DFPS children affected Respite DFPS during the first half of WY17, and the State determined that the 5% growth on top of WY17 would not have been sufficient and therefore matched the WY17 ratio for the annual ratio and the max of WY17 or the average of WY16/17 for the monthly ratio.

Expansion affected the annual Forecast Ratio less than it affected unit per client projections because a child who shows up at least once during a 12-month period would be counted in the annual unduplicated account. The monthly counts include unduplicated children within the month, and therefore several months would not include children who would have been in the waiver had the expansion been completed at the time. The assumption is that the impact from Expansion is approximately twice the amount on the Monthly Average Ratio than the Annual Ratio, and the State therefore increased the Annual Ratio by 2.5% and the Monthly Ratio by 5%.

- 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:

Factor D' represents the cost of other Medicaid services received by YES waiver participants. In order to calculate Medicaid expenditures for all other services provided to YES waiver participants, both claims data from April 1, 2016 to March 31, 2017 was obtained from Texas Medicaid and Health Partnership (TMHP) Vision 21 Data Warehouse and managed care premium rates were used. Factor D' was calculated for 2017 by dividing total expenditures for other Medicaid services in 2017 by the unduplicated number of Yes participants for 2017, $D'_{2017} = \text{total expenditures} / \text{unduplicated participants}$. Factor D'2017 was then used to calculate waiver renewal estimates for years 1-5. The 2016 Health Consumption Expenditures (HCE) Deflator was used to calculate a yearly inflation factor that was applied to the calculation. The calculation for Year 1 renewal Factor is $D'1 = D'_{2017} * HCE1$. Years 2 to 5 were calculated in the same manner: $D'2 = D'1 * HCE2$, $D'3 = D'2 * HCE3$, etc.

- 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:

Factor G is defined as Medicaid expenditures for inpatient psychiatric hospital care that would be incurred for waiver participants if the waiver was not granted. It is assumed that the children would experience one or more inpatient stays during the year without the waiver.

For the purpose of estimating G, claims and encounter data was obtained from TMHP Vision 21 Data Warehouse for April 1, 2016 to March 31, 2017. The target population was defined as any Medicaid children that did not receive YES waiver services and had at least one psychiatric hospitalization during the time period. Psychiatric hospitalization was defined as those inpatient stays where the primary diagnosis of the hospitalization was ICD10 "F01" - "F98".

Factor G was estimated for Yes Waiver year 2017 as, $G_{2017} = \text{Total Expenditures} / \text{unduplicated hospitalized non YES participants}$. Factor G2017 was then used to calculate waiver renewal estimates for years 1-5. The 2016 Personal Consumption Expenditures (PCE) Deflator was used to calculate a yearly inflation factor that was applied to the calculation of the renewal years. The estimate for Year 1 renewal Factor G1, was calculated as $G1 = G_{2017} * PCE1$. Years 2 to 5 were calculated in the same manner: $G2 = G1 * PCE2$, $G3 = G2 * PCE3$, etc.

- 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:

Factor G' represents costs related to outpatient Medicaid services received by Factor G target population-children that did not receive YES waiver services and had at least one psychiatric hospitalization. For the purpose of estimating Factor G,' both claims data obtained from TMHP Vision 21 Data Warehouse for April 1, 2016 to March 31, 2017 and managed care premium rates were used. Factor G' was estimated for 2017 as, $G'_{2017} = \text{Total outpatient expenditures} / \text{Factor G target clients}$. Factor G'2017 was then used to calculate the waiver renewal estimates for years 1-5. The 2016 Health Consumption Expenditures (HCE) Deflator was used to calculate an annual inflation factor that was applied to the calculation of renewal years 1 to 5. The estimate for Year 1 renewal Factor G1, was calculated as $G1 = G'_{2017} * HCE1$. Years 2 to 5 were calculated in the same manner: $G2 = G1 * HCE2$, $G3 = G2 * HCE3$, etc.

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	
Respite	
Supported Employment	
Adaptive Aids and Supports	
Community Living Supports (CLS)	
Employment Assistance	
Family Supports	
Minor Home Modifications	
Non-Medical Transportation	
Paraprofessional Services	
Specialized Therapies	
Supportive Family-based Alternatives	
Transitional Services	

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
Respite Total:						800923.40
Respite Out-of-Home	Hour	118	70.00	10.22	84417.20	
Respite DFPS					79114.20	
GRAND TOTAL:						12645690.17
Total Estimated Unduplicated Participants:						2878
Factor D (Divide total by number of participants):						4393.92
Average Length of Stay on the Waiver:						197

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Day	55	12.00	119.87		
Respite	day	0	0.00	0.01	0.00	
Respite In-Home	Hour	210	140.00	21.68	637392.00	
Supported Employment Total:						1800.82
Supported Employment	15 min	7	38.00	6.77	1800.82	
Adaptive Aids and Supports Total:						728474.40
Adaptive Aids and Supports	Per Item	1245	6.00	97.52	728474.40	
Community Living Supports (CLS) Total:						8086560.78
Community Living Supports (CLS)	15 min	2089	149.00	25.98	8086560.78	
Employment Assistance Total:						13.54
Employment Assistance	15 min	1	2.00	6.77	13.54	
Family Supports Total:						400465.45
Family Supports	15 min	1435	43.00	6.49	400465.45	
Minor Home Modifications Total:						16425.12
Minor Home Modifications	Per item	76	3.00	72.04	16425.12	
Non-Medical Transportation Total:						105185.52
Non-Medical Transportation	per mile	699	264.00	0.57	105185.52	
Paraprofessional Services Total:						481486.50
Paraprofessional Services	15 min	685	110.00	6.39	481486.50	
Specialized Therapies Total:						2002643.52
Specialized Therapies	15 min	1329	136.00	11.08	2002643.52	
Supportive Family- based Alternatives Total:						0.00
Supportive Family-based Alternatives	Day	0	0.00	0.01	0.00	
GRAND TOTAL:						12645690.17
Total Estimated Unduplicated Participants:						2878
Factor D (Divide total by number of participants):						4393.92
Average Length of Stay on the Waiver:						197

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transitional Services Total:						21711.12
Transitional Services	Transition	8	3.00	904.63	21711.12	
GRAND TOTAL:						12645690.17
<i>Total Estimated Unduplicated Participants:</i>						2878
<i>Factor D (Divide total by number of participants):</i>						4393.92
<i>Average Length of Stay on the Waiver:</i>						197

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
Respite Total:						892850.68
Respite Out-of-Home	Hour	128	70.00	10.43	93452.80	
Respite DFPS	Day	61	12.00	122.39	89589.48	
Respite	day	0	0.00	0.01	0.00	
Respite In-Home	Hour	229	140.00	22.14	709808.40	
Supported Employment Total:						1838.06
Supported Employment	15 min	7	38.00	6.91	1838.06	
Adaptive Aids and Supports Total:						812491.20
Adaptive Aids and Supports	Per Item	1360	6.00	99.57	812491.20	
Community Living Supports (CLS) Total:						9020677.54
Community Living Supports (CLS)	15 min	2282	149.00	26.53	9020677.54	
Employment Assistance Total:						13.82
Employment Assistance					13.82	
GRAND TOTAL:						14107255.69
<i>Total Estimated Unduplicated Participants:</i>						3144
<i>Factor D (Divide total by number of participants):</i>						4487.04
<i>Average Length of Stay on the Waiver:</i>						197

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 min	1	2.00	6.91		
Family Supports Total:						446736.03
Family Supports	15 min	1567	43.00	6.63	446736.03	
Minor Home Modifications Total:						18313.95
Minor Home Modifications	Per item	83	3.00	73.55	18313.95	
Non-Medical Transportation Total:						116830.56
Non-Medical Transportation	per mile	763	264.00	0.58	116830.56	
Paraprofessional Services Total:						537182.80
Paraprofessional Services	15 min	749	110.00	6.52	537182.80	
Specialized Therapies Total:						2235383.04
Specialized Therapies	15 min	1452	136.00	11.32	2235383.04	
Supportive Family- based Alternatives Total:						0.00
Supportive Family-based Alternatives	Day	0	0.00	0.01	0.00	
Transitional Services Total:						24938.01
Transitional Services	Transition	9	3.00	923.63	24938.01	
GRAND TOTAL:						14107255.69
<i>Total Estimated Unduplicated Participants:</i>						3144
<i>Factor D (Divide total by number of participants):</i>						4487.04
<i>Average Length of Stay on the Waiver:</i>						197

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
Respite Total:						966209.28
Respite Out-of-Home	Hour	136	70.00	10.65	101388.00	
Respite DFPS	Day	64	12.00	124.96	95969.28	
Respite	day	0	0.00	0.01	0.00	
Respite In-Home	Hour	243	140.00	22.60	768852.00	
Supported Employment Total:						2202.72
Supported Employment	15 min	8	39.00	7.06	2202.72	
Adaptive Aids and Supports Total:						877122.48
Adaptive Aids and Supports	Per Item	1438	6.00	101.66	877122.48	
Community Living Supports (CLS) Total:						9736261.96
Community Living Supports (CLS)	15 min	2413	149.00	27.08	9736261.96	
Employment Assistance Total:						14.12
Employment Assistance	15 min	1	2.00	7.06	14.12	
Family Supports Total:						482369.27
Family Supports	15 min	1657	43.00	6.77	482369.27	
Minor Home Modifications Total:						19601.10
Minor Home Modifications	Per item	87	3.00	75.10	19601.10	
Non-Medical Transportation Total:						127828.80
Non-Medical Transportation	per mile	807	264.00	0.60	127828.80	
Paraprofessional Services Total:						580219.20
Paraprofessional Services	15 min	792	110.00	6.66	580219.20	
Specialized Therapies Total:						2412748.80
Specialized Therapies	15 min	1536	136.00	11.55	2412748.80	
GRAND TOTAL:						15232868.63
Total Estimated Unduplicated Participants:						3325
Factor D (Divide total by number of participants):						4581.31
Average Length of Stay on the Waiver:						197

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supportive Family-based Alternatives Total:						0.00
Supportive Family-based Alternatives	Day	0	0.00	0.01	0.00	
Transitional Services Total:						28290.90
Transitional Services	Transition	10	3.00	943.03	28290.90	
GRAND TOTAL:						1523268.63
Total Estimated Unduplicated Participants:						3325
Factor D (Divide total by number of participants):						4581.31
Average Length of Stay on the Waiver:						197

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
Respite Total:						1024123.62
Respite Out-of-Home	Hour	141	70.00	10.87	107286.90	
Respite DFPS	Day	67	12.00	127.58	102574.32	
Respite	day	0	0.00	0.01	0.00	
Respite In-Home	Hour	252	140.00	23.08	814262.40	
Supported Employment Total:						2249.52
Supported Employment	15 Min	8	39.00	7.21	2249.52	
Adaptive Aids and Supports Total:						931086.00
Adaptive Aids and Supports	Per Item	1495	6.00	103.80	931086.00	
Community Living Supports (CLS) Total:						10332583.80
Community					10332583.80	
GRAND TOTAL:						16163808.25
Total Estimated Unduplicated Participants:						3455
Factor D (Divide total by number of participants):						4678.38
Average Length of Stay on the Waiver:						197

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Living Supports (CLS)	15 Min	2508	149.00	27.65		
Employment Assistance Total:						14.42
Employment Assistance	15 min	1	2.00	7.21	14.42	
Family Supports Total:						511954.99
Family Supports	15 Min	1723	43.00	6.91	511954.99	
Minor Home Modifications Total:						20933.64
Minor Home Modifications	Per item	91	3.00	76.68	20933.64	
Non-Medical Transportation Total:						135112.56
Non-Medical Transportation	Per Mile	839	264.00	0.61	135112.56	
Paraprofessional Services Total:						615604.00
Paraprofessional Services	15 Min	823	110.00	6.80	615604.00	
Specialized Therapies Total:						2561260.80
Specialized Therapies	15 Min	1596	136.00	11.80	2561260.80	
Supportive Family-based Alternatives Total:						0.00
Supportive Family-based Alternatives	Day	0	0.00	0.01	0.00	
Transitional Services Total:						28884.90
Transitional Services	Transition	10	3.00	962.83	28884.90	
GRAND TOTAL:						16163808.25
Total Estimated Unduplicated Participants:						3455
Factor D (Divide total by number of participants):						4678.38
Average Length of Stay on the Waiver:						197

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
Respite Total:						1086255.08
Respite Out-of-Home	Hour	147	70.00	11.10	114219.00	
Respite DFPS	Day	69	12.00	130.26	107855.28	
Respite	day	0	0.00	0.01	0.00	
Respite In-Home	Hour	262	140.00	23.56	864180.80	
Supported Employment Total:						2296.32
Supported Employment	15 Min	8	39.00	7.36	2296.32	
Adaptive Aids and Supports Total:						987521.64
Adaptive Aids and Supports	Per Item	1553	6.00	105.98	987521.64	
Community Living Supports (CLS) Total:						10961539.62
Community Living Supports (CLS)	15 Min	2606	149.00	28.23	10961539.62	
Employment Assistance Total:						14.72
Employment Assistance	15 min	1	2.00	7.36	14.72	
Family Supports Total:						542638.50
Family Supports	15 Min	1790	43.00	7.05	542638.50	
Minor Home Modifications Total:						22077.78
Minor Home Modifications	Per Item	94	3.00	78.29	22077.78	
Non-Medical Transportation Total:						142728.96
Non-Medical Transportation	Per Mile	872	264.00	0.62	142728.96	
Paraprofessional Services Total:						652707.00
Paraprofessional Services	15 Min	855	110.00	6.94	652707.00	
Specialized Therapies Total:						2716512.96
Specialized Therapies	15 Min	1659	136.00	12.04	2716512.96	
GRAND TOTAL:						17143784.08
Total Estimated Unduplicated Participants:						3591
Factor D (Divide total by number of participants):						4774.10
Average Length of Stay on the Waiver:						197

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supportive Family- based Alternatives Total:						0.00
Supportive Family-based Alternatives	Day	0	0.00	0.01	0.00	
Transitional Services Total:						29491.50
Transitional Services	Transition	10	3.00	983.05	29491.50	
GRAND TOTAL:						17143784.08
<i>Total Estimated Unduplicated Participants:</i>						3591
<i>Factor D (Divide total by number of participants):</i>						4774.10
<i>Average Length of Stay on the Waiver:</i>						197