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

1. Major Changes

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

Changes to the Home and Community-based Services waiver requested in this waiver renewal include:

Appendix B: Participant Access and Eligibility
HHSC clarified that the Verification of Freedom of Choice Form, which documents an individual's choice between waiver services and an intermediate care facility for individuals with an intellectual disability or related conditions, is presented at enrollment.

HHSC updated the hyperlink to the Diagnostic Codes for Persons with Related Conditions.

HHSC updated the unduplicated number of participants served, the point-in-time totals, and the reserve capacity totals for all five waiver years.

Appendix C: Participant Services
HHSC clarified language that an individual must be a Medicaid recipient to receive transition assistance services (TAS).

HHSC removed the day habilitation service from the waiver application.

HHSC clarified that the evaluation and recommendation requirements for adaptive aids applies to all adaptive aid purchases.

HHSC clarified the settings where respite may be provided and identified the services that may be provided at the same time as respite to be consistent with current policy.

HHSC clarified that for all waiver services provided using the agency option, a provider agency must ensure that service providers meet applicable qualifications before the service provider provides the service. HHSC also clarified that HHSC verifies during initial certification and recertification surveys that a provider agency meets applicable qualifications.

HHSC also clarified that for all waiver services provided using the consumer directed services (CDS) option, HHSC verifies during reviews that the employer verified service providers met applicable qualifications before they provided services.

HHSC revised the service provider qualifications for respite, financial management services, and dental treatment to be consistent with current policy.

HHSC clarified that financial management services agencies verify and maintain documentation of timesheets for services delivered using the consumer directed services option.

HHSC removed the statement that the individual is responsible for conducting initial and periodic training for CDS respite service providers.

HHSC clarified that the service provider of occupational therapy, physical therapy, and speech and language pathology services must not be the individual's spouse to align with current HCS Billing Requirements.

HHSC clarified that a written evaluation and recommendation are required for minor home modifications costing $1,000 or more, while those costing less than $1,000 require only a recommendation.

HHSC clarified that a written evaluation and recommendation are required for all adaptive aids as outlined in policy.

HHSC deleted a statement in the Provider Qualifications section for dental treatment and behavioral support services that there is "no expected reduction in service providers" because this was added in an amendment in March 2020 when HHSC updated the licensure references and is no longer relevant.

HHSC removed "Vendor Drug" from the reference to the provider agreement for prescription medications to align with current policy.

HHSC clarified language for Financial Management Services in the Frequency of Verification section to make information requested in this section more accurate.

HHSC clarified that a Financial Management Services Agency (FMSA) must score at least 85% on a competency-based test to obtain a provider agreement. HHSC also clarified that FMSAs must attend periodic trainings conducted by HHSC.

HHSC clarified the service limit for the combined total of individualized skills and socialization (ISS) service components. HHSC revised the statement that ISS may not be provided at the same time as community support to reference supported home living instead of community support, as community support is not a HCS service.

Appendix D: Service Delivery
HHSC identified the components of a service plan and included a description of each component. HHSC also clarified the process by which a service plan is developed and that it is subject to HHSC approval. HHSC also revised the service plan development safeguards, service plan development process, and the service plan implementation and monitoring process.

HHSC revised the processes for risk assessment and mitigation.

HHSC removed the statement that reviews of local intellectual and development disability authorities (LIDDAs) are conducted on site because reviews may be on site or by desk review.

HHSC clarified that both the provider agency and LIDDA are required to ensure an individual is informed of the process for filing complaints.

HHSC clarified that the person-directed plan must be developed through a person-centered planning process.

HHSC clarified the responsibilities of LIDDAs under the Service Plan Development Safeguards, Risk Assessment and Mitigation, Service Plan Development, Service Plan Implementation and Monitoring, and Monitoring Safeguards sections.

HHSC used the term “ASPEN” instead of “CARE data system” to reflect a system change.

HHSC added references to annual “recertification surveys” as a type of survey of provider agencies conducted by HHSC.

HHSC clarified the role of the LIDDA to provide targeted case management.

HHSC clarified the role of the Intellectual and Developmental Disabilities (IDD) Ombudsman.

HHSC clarified what must be included in a plan of correction for a provider agency and the steps HHSC takes if a plan of correction is approved to align with existing policy.

Appendix E: Participant Direction of Services
HHSC clarified that support consultation is an optional service that provides assistance and skills training for an employer or designated representative and that a support advisor provides support consultation services.

HHSC clarified that if an individual utilizing the CDS option has a legally authorized representative (LAR), the LAR must serve as the CDS employer on the individual’s behalf to align with existing policy.

HHSC updated the projected number of participants self-directing their services through the CDS option.

HHSC clarified that “service agreements,” not “provider agreements,” are reviewed to assess a financial management services agency’s performance.

HHSC clarified that an individual’s service coordinator assists an individual in revising the individual plan of care and person-directed plan.

HHSC clarified that the service planning team develops the individual’s “person-directed plan” rather than the “service plan” and that HHSC approves the “individual plan of care,” rather than the “person-directed plan.”

HHSC clarified that the consumer directed budget is the estimated cost of the self-directed services in the approved “individual plan of care,” rather than in the “service plan.” HHSC also clarified that revisions to the budget require a revision to the individual plan of care.

HHSC clarified the development of the individual plan of care and the consumer directed services budget, as well as the method for informing the individual of any changes to the individual plan of care and the consumer directed services budget.

Appendix F: Participant Rights

HHSC clarified how an individual is informed of their rights including their right to request a fair hearing.

HHSC clarified that if the individual's services are reduced, denied, or terminated, HHSC sends a letter to the individual describing the action HHSC has taken or will take and gives the individual the right to request a fair hearing and that HHSC retains a copy of any letters sent to the individual regarding an adverse action and a copy of the written request for a hearing.

HHSC clarified the types of complaints received by the IDD Ombudsman and the types of complaints a provider agency reports to HHSC or the LIDDA. HHSC also removed information about the IDD Ombudsman complaint process that duplicates information in Appendices D, F, and G.

HHSC removed the statement, "The individual's service coordinator also advises the individual or legally authorized representative that filing a complaint is not a pre-requisite or substitute for requesting a fair hearing," because similar statements are included elsewhere in the appendix.

HHSC clarified that the LIDDA upon enrollment and annually thereafter, must inform an individual or legally authorized representative orally and in writing of how to file a complaint.

HHSC clarified when the provider agency must inform the individual and legally authorized representative of how to report abuse, neglect and exploitation and of the provider's role in reporting complaints.

Appendix G: Health and Welfare
HHSC revised the participant training and education process related to abuse, neglect, and exploitation to be consistent with current policy.

HHSC revised the timeframe for completing an investigation of an allegation of abuse, neglect, or exploitation to be consistent with current policy.

HHSC clarified its responsibility in overseeing the system for reporting critical incidents and events and implementing safeguards concerning the use of restraints, seclusion, and restrictive interventions.

HHSC clarified that the timeframe for service providers to enter critical incidents in the HHSC data system is no later than the last calendar day of the month that follows the month being reported.

HHSC clarified that provider agencies will only receive the final investigative reports related to abuse, neglect, and exploitation when the alleged perpetrator is a service provider, staff member, volunteer, agent, contractor, sub-contractor, or controlling entity of the provider agency. HHSC included a statement that the Department of Family and Protective Services investigates allegations of abuse, neglect, and exploitation when the alleged perpetrator is a person other than a service provider, staff member, volunteer, agent, contractor, sub-contractor or controlling entity of the provider agency.

HHSC clarified reporting trends for restrictive interventions and HHSC's responsibility in overseeing a provider agency's use and reporting of restraints.

HHSC clarified that both the LIDDA and provider agency are required to inform individuals and their legally authorized representatives of the processes for filing complaints about waiver services and the process for reporting abuse, neglect and exploitation.

HHSC corrected the name of the "National Core Indicators In-Person survey," which was previously referred to as the "National Core Indicators survey." HHSC also revised the time frame in which individuals are included in the survey sample from three years to two years.

HHSC clarified the information that a provider agency must include in an acceptable plan of correction.

Appendix H: Quality Improvement Strategy
HHSC revised the System Design Change section and updated the committee name from "Promoting Independence Advisory Committee" to "The Intellectual and Developmental Disability System Redesign Advisory Committee," and clarified the role of the Intellectual and Developmental Disability System Redesign Advisory Committee.

HHSC revised the frequency of monitoring and analysis to "quarterly."

HHSC used the term “Quality Improvement Strategy” instead of “Quality Oversight Plan” to reflect the accurate terminology.

HHSC removed information about Texas Quality Matters because it is no longer relevant.

HHSC revised the survey tool that describes an individual’s experience regarding care and quality of life.

Due to the character limit in the Renewal - 1. Major Changes section, Renewal – 1. Major Changes continues in the 'Main: B. Optional' section.

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*):

Home and Community-based Services (HCS) Program

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: TX.0110
Draft ID: TX.028.08.00

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

Regular Waiver

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

09/01/23

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

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

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

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

☐ **A program authorized under §1115 of the Act.**
Specify the program:

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

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

2. Brief Waiver Description

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

The Home and Community-based Services (HCS) waiver, first authorized September 1, 1985, provides community-based services and supports to individuals with intellectual and developmental disabilities or a related condition living in a variety of residential settings including an individual's own home, family home, a host home/companion care setting, or a three or four person group home setting. Services and supports are intended to enhance quality of life, functional independence and health and well-being in community-based living as an alternative to institutional living. HCS makes all services available through the provider-managed service delivery option. Using consumer directed services, individuals may choose to self-direct the services of transportation as an activity of supported home living, respite, nursing, employment assistance, supported employment, and cognitive rehabilitation therapy. Individuals enrolling in the waiver are assisted by a service coordinator employed by one of the State's 39 local intellectual and developmental disability authorities. The local intellectual and developmental disability authority serving the geographic area in which the individual lives conducts all enrollment activities in accordance with its performance contract with the Health and Human Services Commission (HHSC). The local intellectual and developmental disability authority service coordinator, using a person-directed planning process, is responsible for facilitating enrollment activities. These include coordinating the development of the individual's initial service plan; informing the individual of the service delivery options (consumer directed and provider managed) for services in the plan; assisting the individual in accessing non-waiver services; and the provision of a list of qualified program providers in the individual's area. In conjunction with the service planning team, the local intellectual and developmental disability authority service coordinator develops the service plan which describes the waiver and non-waiver services the individual will receive.

Once an individual is enrolled in the HCS waiver, ongoing service coordination is provided by the local intellectual and developmental disability authority and the provision of waiver services to the individual is the responsibility of either the program provider or the consumer directed services employer if the individual has chosen to self direct services. Service coordination is provided under the State's Targeted Case Management strategy and is not a service included in the waiver service array. Service coordination includes service planning activities and the coordination and monitoring of both waiver services and non-waiver services an individual may receive. Either the provider agency or the consumer directed services employer if the individual has chosen to self direct services is responsible for providing the waiver services identified in an individual's service plan.

The service coordinator is responsible for service coordination tasks that include: facilitating the development of the individual's service plan using a person-directed focus; identifying, advocating, and collaborating with non-waiver services the individual has an identified need for and linking the individual to those supports; on-going monitoring of both waiver and non-waiver services the individual may receive; recording the individual's progress or lack of progress toward the attainment of desired outcomes from waiver services as identified in the service plan; and record keeping in accordance with waiver requirements. The service coordinator must facilitate revisions to the individual's service plan when the individual's needs change, when the individual or their legally authorized representative indicate a need for a change in the individual's desired outcome for services, or provide other information to the service coordinator that indicates revision of the plan is appropriate.

The provider agency is responsible for providing all HCS services to an individual as identified in the individual's service plan; to coordinate and monitor the delivery of those services; to integrate various aspects of services delivered through the waiver and from non-waiver sources when necessary; to record the individual's progress or lack of progress toward the attainment of desired outcomes from waiver services as identified in the service plan; and record keeping in accordance with waiver requirements.

The local intellectual and developmental disability authority must ensure that the service coordinator utilizes a person-directed planning process for service planning that is consistent with HHSC's Person-Directed Planning Guidelines for Individuals with Intellectual and Developmental Disabilities.

The single State Medicaid Agency, HHSC exercises administrative discretion in the administration and supervision of 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.

HHSC's functions include managing waiver enrollment against approved limits; individual waiver enrollment; monitoring waiver expenditures against approved levels; conducting level of care evaluation activities; reviewing individual service plans to ensure that waiver requirements are met; conducting utilization management and waiver service authorization functions; enrolling providers and executing the Medicaid provider agreements; developing rules, policies, procedures, and information governing the waiver; and quality assurance and quality improvement activities.

The state confirms the Appendix K numbers take precedence over the numbers provided in this renewal.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- (●) **No**
- ( ) **Yes**

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

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

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

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

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the

waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of

care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

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

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

HHSC distributed the HCS renewal Tribal Notification to the Tribal representatives on February 1, 2023. The Tribal Notification provided contact information to request copies of the renewal, provide comments, and request information from the State via email, mail, or telephone. The State provides copies free of charge.

The Public Notice of Intent (PNI) for the HCS Renewal was published in the Texas Register (http://www.sos.state.tx.us/texreg/index.shtml) on February 10, 2023, 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 renewal, provide comments, and, request information from the State via email, mail, or telephone. The State provides copies free of charge.

HHSC also sent a request to the HHSC Office of Social Services to distribute notice of the renewal to 290 local eligibility offices with instructions to post the notice in public areas on February 10, 2023.

HHSC posted the HCS renewal on the HHSC website at https://hhs.texas.gov/laws-regulations/policies-rules/waivers

The public comment period will end on March 13, 2023.

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: Steve

First Name: Fox

Title: Manager of Federal Coordination, Rules and Committees

Agency: Texas Health and Human Services Commission

Address: 701 W. 51st Street.

Address 2: Mail Code H-310

City: Austin

State: **Texas**

Zip: 78751

Phone: (512) 438-4195 **Ext:** ☐ **TTY**

Fax: (512) 323-1905

E-mail: steven.fox@hhs.texas.gov

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

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

Signature:

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: Stephens

First Name: Stephanie

Title: State Medicaid Director

Agency: Texas Health and Human Services Commission

Address: 4601 Guadalupe Street

Address 2:

City: Austin

State: **Texas**

Zip: 78751

Phone:

(512) 428-1906 **Ext:** ☐ **TTY**

Fax:

(512) 487-3403

E-mail:

TX_Medicaid_Waivers@hhs.texas.gov

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:

HHSC submitted the complete transition plan via email; included here are the *Upcoming Changes, Public Notices, and Fair Hearings.*

Upcoming Changes
Effective March 1, 2023, day habilitation will no longer be available as a service to individuals enrolled in the HCS, TxHmL, and DBMD Programs. Individuals will be able to begin revising their individual plans of care (IPCs) when individualized skills and socialization is made available, to add the new service to their IPCs.

On-site and off-site individualized skills and socialization:
- provides person centered activities related to acquiring, retaining, or improving self-help skills and adaptive skills necessary to live successfully in the community and gaining or maintaining independence, socialization, community participation, or future volunteer or employment goals consistent with achieving the outcomes identified in an individual's person-directed plan;
- supports the individual's pursuit and achievement of employment through school, vocational rehabilitation, the HCS service of employment assistance, or the HCS service of supported employment;
- provides personal assistance for an individual who cannot manage their personal care needs during the individualized skills and socialization activity; and
- provides assistance with medications and the performance of tasks delegated by a registered nurse or physician in accordance with state law and rules.

To implement individualized skills and socialization:
- HHSC is drafting rules to address policies and procedures for individualized skills and socialization, establish a rate methodology, and create a licensure process for individualized skills and socialization providers. HHSC expects the rules to be effective by March 1, 2023.
- HHSC will continue to work with program providers and provide them reminders and information to help ensure that they timely assist individuals in transitioning to the new service by March 1, 2023.
- HHSC will revise program billing requirements and handbooks to include the new service by November 14th, 2022.
- HHSC will offer training for program providers prior to the March 1, 2023 deadline to assist with the transition to the new service.

Program providers and service coordinators are expected to ensure that any initial or renewal IPCs don’t include day habilitation on or after March 1, 2023, the date day habilitation ceases to be a service in the HCS Program. Program providers and service coordinators are expected to revise an individual’s IPC by February 29, 2024 to remove day habilitation that has not been provided to the individual. This approach will allow program providers and service coordinators to remove day habilitation from IPCs when they are customarily revised or renewed throughout the IPC period, instead of revising them all at the same time.

Public Notices
HHSC or its designee will provide written notice about the transition from day habilitation to individualized skills and socialization services to individuals at least 30 days in advance of the transition.

Fair Hearings
The state does not believe an opportunity to request a fair hearing is required for this transition. Although day habilitation is being discontinued, it is being replaced with a more robust service, individualized skills and socialization. Therefore, individuals in the HCS Program will not be adversely affected by the transition.

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

HCS Settings Transition Plan

Rule Overview

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

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

HCS Waiver

The State administers the Home and Community-based Services (HCS) program that provides home and community-based services to individuals with an intellectual disability as an alternative to living in an intermediate care facility for individuals with intellectual disabilities. Recipients can live in their own homes, their families' homes, in host home/companion care settings, or in residences with no more than three others who receive similar services. HCS rules require providers to justify any restriction of rights and support the principles set forth in the new HCBS regulations.

A comprehensive list of settings for HCS waiver services (which can be found in 40 TAC §9.174) is as follows:

waiver participant’s own home or family home;

provider owned or operated residences (host home/companion care setting or 3-person or 4-person residences in which residential support services);

day habilitation settings; and

non-residential community/public settings (including but not limited to libraries, parks, shopping centers, offices);

The State presumes that settings consisting of the individual's own home or family home or a public place are compliant. All other settings in the HCS waiver will be assessed for compliance with the HCBS final rule as part of the assessment process described below and referenced as "HCS waiver settings."

HCS Settings Transition Plan

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

Assessment Process:

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

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

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

Provider assessments: The State may administer surveys of providers and include a validity check against self-evaluations.

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

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

In the first phase of the assessment process, Texas conducted a systemic/internal review of current waiver program rules and policies identifying areas that were in compliance with the new regulation, non-compliant, or silent. In addition, the State reviewed oversight processes to determine if revisions were needed to ensure ongoing compliance with new HCBS rules. The results of the systemic/internal review of rules and policies yielded an assessment document for the 1915(c) waivers operated by the Texas Department of Aging & Disability Services (DADS) that outlined areas of compliance and non-compliance across all of the waiver programs, including the HCS waiver. The document indicated whether the rules and policies were silent, non-compliant or partially compliant. DADS has concluded from the first phase of the assessment process that continued assessment of settings for compliance with federal requirements is indicated. The assessment document titled "Impact of Federal HCBS Rules on DADS 1915(c) Waiver Process," is posted on the DADS website at http://www.dads.state.tx.us/providers/HCBS/hcbs-settingsassessment.pdf allowing ongoing input on the assessment process. The Texas Health & Human Services Commission (HHSC) website (http://www.hhsc.state.tx.us/medicaid/hcbs/index.shtml) also links to the DADS website to support access to the assessment document.

In July 2014 the State gave public notice for a preliminary settings transition plan for the HCS waiver. Comments received were considered for incorporation into the assessment. The HCS portion of the preliminary plan was submitted to CMS with HCS Waiver Amendment 3 on August 29, 2014, and CMS approved the Amendment on November 26, 2014.

The State presumes that settings consisting of the individual's own home or family home or a public place are compliant. Provider-owned and -operated settings will be assessed by December 2015 (the end of the assessment phase).

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

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

-The State sought public input on the waiver specific preliminary settings transition plans for all of the 1915(c) waivers through

an open meeting for stakeholders and the general public on October 13, 2014. The meeting was also webcast to allow for greater participation across the state. The State accepted public testimony on waiver specific preliminary settings transition plans and additional recommendations for improving the assessment process for all of the 1915(c) waivers.

- Provider self-assessment surveys: In order to validate the results of the first assessment phase, DADS is releasing a provider self-assessment survey to a representative sample of providers. The survey will be based on the exploratory questions provided by CMS with input from external stakeholders. The provider self-assessment survey will be developed in conjunction with providers, provider associations and advocacy organizations to ensure a comprehensive approach. Providers who are not a part of the sample can still obtain and complete a self-assessment survey on the agency websites and provide data that will be considered as the State moves forward. Based on the results of the survey, ongoing remediation strategies and the assessment document will be updated.

- Participant surveys: In order to validate the provider self-assessment surveys, DADS is releasing a participant survey to a representative sample of individuals receiving services. The survey will be based on the questions asked in the provider self-assessment. Participants who are not a part of the sample can still obtain and complete a participant survey on the agency websites and provide data that will be considered as the State moves forward. Based on the results of the survey, ongoing remediation strategies and the DADS assessment document will be updated.

- Stakeholder meetings: The State is developing a plan for holding meetings around the state to allow providers, advocates, individuals receiving services, legally authorized representatives and other interested parties the opportunity to comment on all 1915(c) waiver programs and any concerns regarding compliance with the new regulations.

- National Core Indicators (NCI) Data: The State is in the process of analyzing NCI data and will consider using it in the assessment process.

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

Third Phase of Assessment [June 2015-May 2016]

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

Remedial Strategy:

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

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

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

State Activity
Texas has identified a number of remediation strategies to address issues of potential non-compliance:

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

- Provider education: Providers will have multiple opportunities to learn about the new regulations and understand rule and policy changes. The State will offer webinars as a main source for provider education in addition to revising new provider orientation curriculum.

Texas does not have any settings in the current 1915(c) Medicaid waivers that are presumed not to be community-based settings according to the regulations. The only possible exception may be day habilitation sites. However, if the State determines the need to submit evidence to CMS for the application of heightened scrutiny for settings that are presumed not to be home and community- based, the Settings Transition Plan will be amended to rebut the presumption or provide a transition plan for the individuals.

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

Public Input and Notice:

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

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

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

State Activity

The State intends to reach out throughout the transition to State staff, providers, advocates, and individuals receiving services and their families. Through various venues, the State plans to educate providers about their responsibilities, help individuals understand their rights under the new HCBS requirements, and solicit input.

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

The public had an opportunity to make comments on the HCS preliminary settings transition plan published in July 2014 and the Texas Statewide Settings Transition Plan (which included the HCS waiver settings transition plan) in November 2014.

HHSC distributed the Texas Statewide Settings Transition Plan Tribal Notification to the tribal representatives on October 20, 2014, in compliance with the 60 day federal and state requirements. The Tribal Notification provided contact information for requesting additional 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 or requests for copies.

The Public Notice of the Texas Statewide Settings Transition Plan was published in the Texas Register on November 7, 2014, 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 statewide through paid subscription; subscribers include cities, counties and public libraries throughout the state. The PNI provided contact information to request copies of the amendment from the State via email, mail, or telephone. The State provides copies free of charge.

The public notice provided information about the Texas Statewide Settings Transition Plan. The State provides copies free of charge. The "Statewide Settings Transition Plan" was posted on the HHSC, DADS and DSHS websites. The websites also provided links to make comments.

o http://www.hhsc.state.tx.us/medicaid/hcbs/index.shtml
o http://www.dshs.state.tx.us/mhsa/yes/
o http://www.dads.state.tx.us/providers/HCBS/index.cfm

The "HCS Settings Transition Plan" (which was taken from the Texas Settings Transition Plan) was posted on the DADS website in November 2014.

The State received comments and submitted comments specific to the HCS waiver program from the July 2014 preliminary plan public notice and submitted those comments and responses with HCS Amendment 3, on August 29, 2014. The amendment, including the preliminary plan, was approved on November 26, 2014.

State staff posted an updated HCS Settings Transition Plan with HCS Amendment 5 on the DADS website http://www.dads.state.tx.us/providers/hcs/ on April 16, 2015. During the public comment period, no comments were received.

DADS concluded from the first phase of the assessment process that continued assessment of settings for compliance with federal requirements is indicated. The settings assessment document, titled "Impact of Federal HCBS Rules on DADS 1915(c) Waiver Process," is posted on the DADS website at http://www.dads.state.tx.us/providers/HCBS/hcbs-settingsassessment.pdf allowing ongoing input on the assessment process. The Texas Health & Human Services Commission (HHSC) website (http://www.hhsc.state.tx.us/medicaid/hcbs/index.shtml) also links to the DADS website to support access to the assessment documents.

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

- Stakeholder education webinars: DADS conducted two webinars on September 11 and September 14, 2014, to provide all stakeholders an opportunity to learn about the new regulations prior to the October 13, 2014 open meeting held in Austin.

- Stakeholder meetings: On October 13, 2014, the State held an open stakeholder meeting in Austin providing all stakeholders the opportunity to provide input on the new regulations. The meeting was also webcast to allow for greater participation across the state. The State accepted public testimony on waiver specific preliminary settings transition plans and additional recommendations for improving the assessment process for all of the 1915(c) waivers.

- Electronic notices: The State posted the Statewide Settings Transition Plan on agency websites and in the Texas Register in November 2014. The DADS assessments were also posted on the agency website. The preliminary transition plans for several of the waivers were posted in the Texas Register and on the agency websites.

- Feedback mechanism: Dedicated electronic mail boxes and websites for HHSC and DADS are available to provide information about the new rules and accept feedback. The websites and the option to make comments will remain active throughout the transition and the State will take any comments received into consideration, until the State completes the transition. State websites are located at the following:

http://www.hhsc.state.tx.us/medicaid/hcbs/index.shtml

http://www.dads.state.tx.us/providers/HCBS/index.cfm

- Presentations at statutorily mandated committees: The State regularly provides updates to the following groups and offers them opportunities to comment on ongoing assessment and remediation activities:
-Promoting Independence Advisory Committee: comprised of individuals receiving services, advocacy organizations, and providers across target populations.
-Employment First Task Force: comprised of advocates and providers interested in employment issues.
-Texas Council on Autism and Pervasive Developmental Disorders: comprised of parents of individuals with autism and professionals.
-IDD Redesign Advisory Committee: comprised of individuals receiving services, advocacy organizations and providers.

- Presentations at agency workgroups: The agencies also have agency-established workgroups comprised of advocates and providers whose purpose is to examine ongoing rule and policy issues. Staff will provide updates on HCBS transition activities and provide the workgroup members the opportunity to provide comments.
- Presentations at conferences: Provider associations hold annual conferences and State staff have been invited to speak at these conferences. This provides access to a large number of providers for purposes of education, coordination and input regarding changes being made to rules and policy.

For more information or to obtain free copies of the HCS Settings Transition Plan, you may contact Micah Erwin by mail at Texas Health and Human Services Commission, P.O. Box 13247, Mail Code H-370, Austin, Texas, 78711-3247 phone (512) 424-6549, fax (512) 730-7472 or by email at TX-_Medicaid_Waivers@hhsc.state.tx.us.

Timeline of HCS Settings Transition Plan
*Represents milestone activities

ASSESSMENT OF HCS WAIVER SETTINGS

* Phase I: March 2014 - September 2014

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

2) State staff identification of areas in which policy and rules appeared to be silent or in contradiction with new HCBS rules.

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

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

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

* Phase II: September 2014 - December 2015

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

2) November 2014 – December 2014: Public notice and comment period for the Texas Statewide Settings Transition Plan which includes the HCS settings transition plan.

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

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

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

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

7) The State will update the assessment after completion of the entire assessment phase.
The update to the assessment will be posted on the agency websites. If, As a result of the assessment, there was a change in assessment findings, or the State has added additional remedial action and milestones, the State will submit an amendment or modification to the transition plan, after the required public notice and comment period.

Phase III: January 2015 - May 2016

1) January 2015 – May 2016: DADS will survey a representative sample of non-residential providers (including day habilitation providers) to ascertain whether providers are in compliance with CMS guidance

2) July 2015 – May 2016: A representative sample of provider self-assessments will be verified by a representative sample of participant surveys.

PUBLIC INPUT

1) July 2014: Preliminary Settings Transition Plans for HCS available for public comment through posting in the Texas Register.

2) July 18, 2014: Preliminary Settings Transition Plan for HCS available for public comment through posting on the DADS website. 1) *July 2014 – September 2014: Internal assessment document outlining compliance and non-compliance with settings requirements across all 1915(c) waivers operated by DADS posted for public input.

2) July 2014 continuing through the end of the transition period: Presentations to statutorily mandated committees and agency workgroups that have provider and advocate membership will continue throughout the assessment process. Stakeholders will have multiple opportunities to provide input.

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

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

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

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

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

8) April 2015- May 2015: The HCS Settings Transition Plan posted for public comment. The following forms of public notice were utilized: notice in the Texas Register, on the DADS website, and a request sent 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.

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

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

State websites are located at the following:

http://www.hhsc.state.tx.us/medicaid/hcbs/index.shtml

http://www.dads.state.tx.us/providers/HCBS/index.cfm

REMEDIATION OF HCS WAIVER SETTINGS

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

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

3)* January 2016 – May 2017: Amend HCS program rules and Chapter 49 contracting rules to address all HCS waiver settings. Stakeholder input is actively solicited during the rule making process.

4) June 2016 – May 2017: Revise the HCS policy manual, including rights and responsibilities forms/publications and billing guidelines to further outline HCBS requirements for all HCS waiver settings.

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

6) December 2016 – July 2017: Revise residential review process to incorporate focus on HCBS setting requirements based on rule revisions. Residential reviewers monitor HCS providers annually to ensure compliance with the program rules.

7) December 2016 – July 2017: Revise certification review process for all HCS waiver settings, to incorporate focus on HCBS setting requirements based on rule revisions. Certification reviewers monitor HCS providers to ensure compliance with program rules.

8) August 2017 – December 2017: Review and include appropriate revisions to the HCS Settings Transition Plan.

9) January 2018 – February 2018: Public notice and public comment period for review of the revised HCS Settings Transition Plan.

10) *March 2018 – March 2018: Submit HCS amendment updating the HCS Settings Transition Plan with appropriate changes based on public input after the required public notice.

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

12) June 2017 – July 2018: Revise the HCS policy manual, including rights and responsibilities forms/publications and billing guidelines to further outline HCBS requirements for day habilitation based on CMS guidance.

13) June 2017 – September 2018: Revise certification review process to incorporate focus on HCBS setting requirements based on day habilitation rule revisions. Residential reviewers monitor HCS providers annually to ensure compliance with program rules.

14) December 2017 – August 2018: Review and include appropriate revisions to the HCS Settings Transition Plan.

15) August 2018 – September 2018: Public notice and public comment period for review of the revised HCS Settings Transition Plan.

16) *October 2018 – October 2018: Submit HCS amendment updating the HCS Settings Transition Plan with appropriate changes based on public input after the required public notice.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Due to the character limit in the Renewal - 1. Major Changes, the response to Renewal – 1. Major Changes is continued below.
Appendix I: Financial Accountability
HHSC revised the provision regarding electronic visit verification (EVV) transactions to remove outdated information regarding the creation of billing codes for respite and individualized skills and socialization for the purposes of EVV.

HHSC clarified the sample size of FMSA record reviews.

HHSC clarified the rate methodology process and the use of Personal Consumption Expenditures (PCE) forecast.

HHSC clarified the rate methodology for audiology, social work, support consultation and FMSA.

HHSC clarified the notice process related to proposed rate adjustments.

Appendix J: Cost Neutrality Demonstration
HHSC updated the unduplicated number of participants to the total in the previous waiver renewal year five totals for all five waiver years. HHSC also updated the service projections (Factor D), and the waiver recipients other Medicaid cost projections (Factor D') and projections for annual average per capita Medicaid costs for all non-waiver institutional services (Factor G) and other Medicaid costs for the institutional population (Factor G') for all five waiver years.

Performance Measures
HHSC added an administrative authority performance measure, A.a.1, based on direction from CMS, for the "number and percent of individuals on the HCS interest list who are offered waiver services on a first-come, first served basis by HHSC."

HHSC revised performance measure B.c.1, as well as the numerator and denominator, to use the term "new enrollees" instead of "newly enrolled." HHSC further revised the performance measure and numerator to include the phrase "using approved processes and instruments," and revised the denominator to include the phrase "who received at least one service." The revised measure reads as, "B.c.1 Number and percent of new enrollees with initial LOCs completed prior to receipt of first service using approved processes and instruments. N: Number of new enrollees with initial LOCs completed prior to receipt of first service using approved processes and instruments. D: Number of new enrollees requiring initial LOC determinations who received at least one service."

HHSC revised performance measure C.a.3, as well as the numerator and denominator, to use the term "certification principles," and to remove the requirement that contracts are surveyed "according to the schedule required by policy." The revised measure reads as, "Number and percent of contracts surveyed to ensure that providers are initially and continually meeting all certification principles."

HHSC revised performance measure C.a.4 denominator to add the phrase "placed on vendor hold" and remove the phrase "released from vendor hold plus those moved to decertification because of a failure to be released from vendor hold." The revised denominator reads as, "Number of contracts placed on vendor hold."

HHSC revised performance measure C.b.1, as well as the numerator and denominator, to use the phrase newly enrolled "financial management agency contracts."

HHSC revised performance measure C.b.2 and C.b.3, as well as the numerators and denominators, to use the term "financial management services agency contracts" and to use "overall compliance score" instead of "overall monitoring score."

HHSC revised performance measure C.c.1 as well as the numerator and denominator to use the term "newly enrolled contracted providers" instead of "providers" and use the term "initial provider training" instead of "provider training."

HHSC revised performance measures C.c.2, as well as the numerator and denominator to include the term "initial required training" instead of "required training" and use the term "newly enrolled FMSAs" instead of "monitored financial management services agencies."

HHSC revised performance measures D.a.1, D.c.2, D.d.1, G.a.4, G.a.6 and G.d.1 and the numerators to include the terms "surveyed contracts" or "surveyed service plans." HHSC also revised the denominators to include the term "surveyed contracts".

HHSC revised performance measure D.c.1. to use "Quality Assurance and Improvement Data Mart" instead of "Client Assignment and Registration System."

HHSC revised performance measure G.a.6 to use “ASPEN” instead of “Waiver Survey and Certification Database.”

HHSC revised the sampling approach for the following performance measures C.a.2, C.a.3, D.a.1, D.c.2, D.d.1, D.e.1, D.e.2, G.a.4, G.a.6, G.a.9, G.b.1, G.c.1, G.c.2, G.c.3, G.d.1 and I.a.3.

HHSC revised performance measure G.a.7, as well as the numerator, to add the phrase “during the required timeframe.”

HHSC revised performance measure G.a.8 and the numerator to address “individuals free from previous confirmed allegations of abuse, neglect, or exploitation within three months prior to the date of death” instead of “individuals free from previous confirmed allegations of abuse, neglect, or exploitation within the last three months.” HHSC also revised the denominator to include the phrase “Number of provider-reported deaths received during the reporting period” instead of “Number of provider-reported deaths.”

HHSC revised performance measures G.b.2 Data Source to reflect the accurate system used, “HHS Enterprise Admin Reporting and Tracking System” instead of “Consumer Rights and Services Intellectual Disability Database”

HHSC added a new performance measure, G.b.3 that reads “Number and percent of surveyed contracts not decertified for failure to address critical incidents according to program rules.”

HHSC added a new performance measure, G.b.4, that reads “Number and percent of surveyed contracts without an administrative penalty imposed for failing to address critical incidents according to program rules.”

HHSC revised performance measures G.c.1 and G.c.2 and the numerators to reflect the number and percent of surveyed contracts that were “not cited for the use of unauthorized” restrictive interventions and “not cited for the use of unauthorized restraint” respectively.

HHSC revised performance measure G.c.3 as well as the numerator, to include the phrase “not cited for the use of seclusion.”

HHSC revised performance measure G.d.1 as well as the numerator, to include the phrase “surveyed contracts that include individuals with reviewed records” and revised the denominator to include the phrase “number of surveyed contracts.” HHSC also revised the sampling approach.

HHSC revised performance measures C.a.2, C.a.3, D.a.1, D.c.2, D.d.1, G.a.4, G.a.9, G.b.1, G.c.1, G.c.2, G.c.3 and G.d.1 to reflect the accurate system being used: “ASPEN” instead of “Client Assignment Registration System.”

HHSC revised performance measure I.a.1 and I.a.3 to reflect the appropriate database used: “Provider Fiscal Compliance Database” instead of “Billing and Payment database.”

HHSC revised performance measure I.b.1 to reflect the accurate department name: “Provider Finance Department” instead of “Rate Analysis Department.”

HHSC revised performance measure I.a.3 as well as the numerator, to use the term “provider agencies” instead of “provider” and to use the phrase “not requiring a corrective action plan evidenced by an overall fiscal compliance score of at least 90%” instead of “not requiring a corrective action plan due to billing and payment error rates greater than 15 percent.”

Miscellaneous
HHSC removed references to the Department of Aging and Disability Services because that state agency was abolished in 2017 and its functions related to the HCS waiver program transferred to HHSC.

HHSC used the term “service provider” instead of “provider” and the term “provider agency” instead of “program provider.”

HHSC updated references to the Texas Administrative Code (TAC) throughout the waiver including changing references to Title 40 to Title 26. Rules of the former Department of Aging and Disability Services, which were in Title 40, are being transferred to Title 26.

HHSC used the term “HHSC data system” instead of “CARE” or “Salesforce.”

HHSC revised the methods for remediation under Appendices A, C, D, G, and I to be consistent with current policy and practice.

HHSC used the term “Provider Fiscal Compliance” instead of “Billing and Payment” to reflect the current name of the HHSC program area.

HHSC used the term “HHSC Long-Term Care Regulation” instead of “Waiver Survey and Certification” and “DADS Regulatory” to reflect the current name of the HHSC program area.

HHSC used the term “professional” therapies instead of “specialized” therapies to reflect the accurate terminology.

HHSC used the term “HHSC IDD Ombudsman” instead of “HHSC Consumer Rights and Services” to reflect the current name of the HHSC program area.

HHSC used the term “Federal Coordination, Rules and Committees” instead of “Policy Development Support.”

HHSC used the term “Adverse Action Review Committee” instead of “Sanction Action Review Committee.”

HHSC changed the term “Rate Analysis Department” to “Provider Finance Department” to reflect the current name of the program area.

HHSC used the term “Department of Family and Protective Services Statewide Intake,” instead of “Department of Family and Protective Services,” to describe complaints related to health and welfare and clarified the complaint process for the Department of Family and Protective Services Statewide Intake.

HHSC updated the unduplicated number of participants, point-in-time numbers, and reserve capacity group numbers, as well as the service projections, projections for consumer directed services participants, and projections for annual average per capita Medicaid costs for all non-waiver institutional services (Factor G) and other Medicaid costs for the institutional population (Factor G’) for all five waiver years in Appendices B, E, and J.

Due to the character limit in D.1.b, the response to D.1.b is continued below.

HHSC Contract Accountability and Oversight reviews the administrative functions of the LIDDA annually, including the provision of service coordination through performance contract reviews to ensure that enrollment, service coordination, and continuity of care functions are conducted in the best interests of the individual. HHSC monitoring elements include verification of freedom of choice of service providers, verification that a complete list of available service providers have been given to individuals and that individuals are informed no less than annually of their right to choose another HCS service provider at any time by requesting assistance from their service coordinator. Individuals are also given a full list of all of the services in HCS, and the LIDDA service coordinator is required to discuss all of the services and the individual’s needs.

Additionally, HHSC Long-Term Care Regulation conducts certification reviews at least annually of all HCS service providers who hold Medicaid provider agreements and who are providing services to at least one individual, at which time a sample of individuals, LARs, or both are interviewed and records are reviewed to determine whether the HCS service provider is in compliance with all of the HCS certification principles. A LIDDA is required to ensure an individual is informed orally and in writing of the process for filing complaints. The administrative section of the LIDDA is required to have a policy in place outlining the process for filing complaints pertaining to service coordination and is required to provide the individual receiving service coordination services with the policy. The provider services section of the LIDDA is required to have a policy in place outlining the process for filing complaints pertaining to provision of HCS waiver services and is required to provide the individual receiving provider services with the policy. Individuals in HCS must be provided the toll-free telephone number to IDD Ombudsman unit to file complaints regarding service provision or service coordination. The IDD Ombudsman will conduct an investigation of all complaints received, other than those for abuse, neglect, and exploitation. Any unresolved complaints will be forwarded to the appropriate department for additional follow-up. Entities that develop the service plans and provide services are not able to do so without prior approval by the State.

Due to the character limit in I-2-a, the response to I-2-a is continued below.

HHSC has developed an add-on to the direct care portion of the supervised living and residential support services rates. This add-on will increase the direct care portion of the supervised living and residential support services rates until current data is available to determine whether the historical model is appropriate. The add-on will be effective until August 31, 2023. During the time period the add-on is in effect, HHSC is implementing a mandatory spending requirement for the supervised living and

residential support services direct care add-on to ensure that providers spend these funds on direct care staff. This spending requirement is separate from the attendant compensation rate enhancement. Providers are required to spend 90 percent of their total supervised living and residential support services direct care add-on revenues on attendant compensation.

Participating providers must submit cost or accountability reports to HHSC documenting their spending on attendant compensation. Each provider's compliance with the add-on spending requirement will be made on an annual basis from the cost or accountability reports. Individuals failing to meet their spending requirement will have their add-on revenues associated with the unmet spending requirements recouped. At no time will a provider's direct care portion of the rate after their spending recoupment be less than the base rate. For purposes of the supervised living and residential support services direct care add-on, the base rate is the current direct care rate or, for participants in the attendant compensation rate enhancement, the current direct care rate plus the applicable rate enhancement add-on. The federal portion of any recouped funds is returned to the federal government.

HHSC holds a public hearing before it approves rates. The purpose of the hearing is to give interested parties an opportunity to comment on the proposed rates. Notice of the hearing is provided to the public via the Texas Register and the HHSC website. The notice of the public hearing includes information about the proposed rate changes and identifies the name, address, and telephone number of the staff member to contact for the materials pertinent to the proposed rates. At least ten working days before the public hearing takes place, material pertinent to the proposed statewide uniform rates is made available to the public. The public may present comments at the hearing or submit written comments regarding the proposed rates.

While the proposed rate changes expire at the conclusion of WY 3, the state anticipates that the historical cost data that is used for the underlying existing methodology will incorporate the costs incurred from these time-limited increases beyond the current methodology. In the future, should the cost data provide evidence that the increases should be sustained, HHSC plans to propose rate increases under the existing methodology. The rate process will include public comment periods on proposed rates, as required by state and federal regulations. In addition, HHSC is conducting monthly meetings with providers and other stakeholders to examine issues related to the waiver, including the rate methodology, over the course of WY2. The state intends to use the information from these meetings to seek public input on any potential methodological changes that it feels are appropriate for WY4 and WY5. Therefore, the state did not update I-2a at this time.

Funding for the enhancement add-on rate levels is limited by appropriations.

Service providers are notified of the open enrollment period for the attendant compensation rate enhancement program electronically or by other appropriate means as determined by HHSC. New providers are notified of the program and enrollment requirements as HHSC is notified of the contract award. A webinar to review the program and respond to questions is held during the open enrollment period. Changes to the rule related to the program at Title 1 of the Texas Administrative Code, Part 15, Chapter 355, §355.112 are published in the Texas Register for public comment.

Service providers participating in the attendant compensation rate enhancement agree to spend approximately 90 percent of their total attendant revenues, including their enhanced add-on rate revenues, on attendant compensation. Attendant compensation includes salaries, payroll taxes, benefits, and mileage reimbursement. Participating providers must submit reports to HHSC documenting their spending on attendant compensation.

Determination of each service provider's compliance with the attendant compensation spending requirement will be made on an annual basis from the reports submitted to HHSC. Participants failing to meet their spending requirement for the reporting period will have their enhanced add-on revenues associated with the unmet spending requirements recouped. At no time will a participating service provider's attendant care rate after their spending recoupment be less than the rate paid to service providers not participating in receiving the enhanced add-on rates. The federal portion of any recouped funds is returned to the federal government.

HHSC uses projected cost from the 2020 cost report and modeled staffing ratios to calculate the initial modeled rates for Individualized Skills and Socialization services.

The initial model-based rate for Individualized Skills and Socialization uses day habilitation services costs from the most recently examined Medicaid cost report, adjusted from daily to hourly to calculate a weighted median cost. Weighted median staff costs are adjusted for anticipated staffing ratios for on-site and off-site services for each level of need and inflated from the cost reporting year to the prospective rate year. The initial model-based rates include a transportation component calculated using the most recent Day Activity and Health Services (DAHS) driver and transportation costs, including vehicle depreciation, fuel and maintenance. Once cost report data for Individualized Skills and Socialization services is available, rates will be set based on a weighted median methodology using the most recently examined cost report. The Individualized Skills and Socialization

rates are rebased every biennium from the most recent projected cost report data, within available appropriations.

Due to the character limit in G-Quality Improvement-b.i, the response to G-Quality Improvement-b.i is continued below. HHSC ensures oversight of local intellectual and developmental disability authorities and remediation through a review of service coordination for waiver participants. The HHSC review includes review of the qualifications and training requirements for service coordinators, the provision of service coordination service, record review of each sample individual's record, and meetings with assigned service coordinators and individuals or their legally authorized representatives, at the discretion of the review team members. Technical assistance is provided during the review and a formal debriefing is held prior to the determination of final findings. The local intellectual and developmental disability authority is then given up to one hour following the formal debriefing to provide additional information that may alter or clear findings. At the conclusion of the review, a final report of the review is provided to the local intellectual and developmental disability authority.

A local intellectual and developmental disability authority may request reconsideration of finding(s) of the review within 10 business days of receipt of the review report, based on the evidence originally submitted at the time of the review.

Barring a successful request for reconsideration of findings, if any item is cited as "Not Met," a corrective action plan will be required for all items of non-compliance. The corrective action plan is due within 30 days of receipt of the report of findings. The corrective action plan must have a projected completion date within 90 days of receipt of the report of findings. Following the projected completion date, a corrective action plan compliance review (CCR) is conducted to verify these specific findings were corrected. Failure to submit a corrective action plan or failure to correct an item of non-compliance will result in a remedy or sanction.

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:

Medicaid and CHIP services

(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:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

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	☒

Function	Medicaid Agency
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.

Performance Measure:
A.a.1 Number and percent of individuals on the HCS interest list who are offered waiver services on a first-come, first served basis by HHSC. N: Number of individuals on the HCS interest list who are offered waiver services on a first come, first-served basis D: Number of individuals who are offered enrollment from the interest list.

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

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

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

Data Aggregation and Analysis:

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

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

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 holds quarterly meetings to evaluate current quality systems and has a formal process to ensure that the waiver renewal, waiver amendments, CMS-372 reports, Request for Evidentiary Information reports, and all state rules for waiver program operations are reviewed and approved.

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.

HHSC employs a variety of strategies for resolving performance issues in a timely manner. These strategies have varying levels of formality and include:

Informal Conversations

Day to day, HHSC staff function in a collaborative manner to support the operation and administration of the waiver.

Waiver Strategic Planning Meetings

Waiver strategic planning occurs at routine meetings where a workgroup evaluates changes needed to the existing waiver, including those identified via legislative mandates or directives from CMS. Waiver activities, including renewals, amendments, and agency remediation activities, are discussed and methods and timing for formal communications with CMS about changes needing formal approval are planned.

Elevated Conversations

If an issue is urgent or persistent and is not resolved through informal communication or through discussion at waiver strategic planning meetings, HHSC staff bring the issue to the attention of leadership. Discussions with HHSC leadership are the final stage of informal communication in an attempt to resolve issues without moving to more formal actions.

Action Memos

Action memos are formal communications from agency staff to the HHSC Executive Commissioner. Action memos are utilized as needed to ensure leadership at the highest level is informed and approve necessary actions to correct problems and ensure improvements.

Plans of Correction

HHSC may require a written plan to correct or resolve issues with performance. The plan of correction must provide a detailed explanation of the reasons for the cited deficiency, an assessment or diagnosis of the cause, a specific proposal to resolve the deficiency, and a timetable including intermediate steps leading to final resolution. Additionally, HHSC may require staff to produce reports to demonstrate that the deficiency has been corrected and to monitor performance for a specified period of time.

ii. Remediation Data Aggregation

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

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

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**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☒	**Developmental Disability**	0		☒
	☒	**Intellectual Disability**	0		☒
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

  Specify the percentage: [ ]

- (●) **Other**

  Specify:

The cost limit for the waiver is based on the level of need of the individual being served. The cost limit based on level of need is as follows:

Intermittent (Level of Need 1), Limited (Level of Need 5), and Extensive (Level of Need 8): $167,468

Pervasive (Level of Need 6): $168,615

Pervasive plus (Level of Need 9): $305,877

Level of Need 2,3,4, or 7 do not exist. Information technology limits the numbering to 1,5,8,6,and 9.

An individual's level of need is reassessed at least annually and as the individual's needs change.

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise

eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

The waiver is intended to serve individuals who would require institutionalization in an intermediate care facility for individuals with an intellectual disability or related condition if the waiver services and supports were not available to them. All individuals must have a plan of care at a cost within the cost limit. For individuals with needs that exceed the cost limit, the State has a process to ensure their needs are met. The process includes examining third-party resources, possible transition to STAR PLUS, or institutional services.

An applicant whose request for eligibility for the waiver is denied or is not acted upon with reasonable promptness is entitled to a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A. For an applicant whose request for eligibility for the waiver is denied, HHSC sends written notification to the applicant, indicating the applicant's right to a fair hearing and the process to follow to request a fair hearing. The procedures for a fair hearing are provided in Appendix F of this waiver application. The individual is also informed of and given the opportunity to request administrative review of a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter R.

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

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

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

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

☒ **Other safeguard(s)**

Specify:

The process which ensures that individuals' health and welfare needs are met includes:
- examining the availability of non-waiver resources
- transitioning the individual to institutional services, or
- possible use of state funds to cover costs above the cost limit.

If the State proposes to terminate the individual's waiver eligibility or reduce services, the State gives the individual the opportunity to request a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A.

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	29819
Year 2	29819
Year 3	29819
Year 4	29819
Year 5	29819

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	29234
Year 2	29234
Year 3	29234
Year 4	29234
Year 5	29234

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
Individuals under age 22 leaving a nursing facility (MFP/PI)
Individuals under age 22 leaving a medium or small intermediate care facility for individuals with an intellectual disability or related condition (PI)
Individuals with level of care I or VIII residing in or at imminent risk of entering a nursing facility (PI)
Individuals leaving a large intermediate care facility for individuals with an intellectual disability or related condition, including a state supported living center (PI)

Purposes
Individuals at risk of imminent institutionalization
Individuals who previously moved from a state supported living center to a community Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition
Individuals leaving a state hospital
Individuals currently residing in an Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition scheduled for closure (PI)
Individuals at risk of institutionalization in a state supported living center
Children in conservatorship leaving a general residential operation
Individuals leaving 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):*

Individuals under age 22 leaving a nursing facility (MFP/PI)

Purpose *(describe):*

This Promoting Independence target group reserves capacity for individuals under the age of 22 years who are receiving services in a nursing facility and who are registered as waiting for waiver services.

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10
Year 5	10

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):*

Individuals under age 22 leaving a medium or small intermediate care facility for individuals with an intellectual disability or related condition (PI)

Purpose *(describe):*

This Promoting Independence target group reserves capacity for individuals under the age of 22 years leaving a medium or small intermediate care facility for individuals with an intellectual disability or related condition.

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	31
Year 2	31
Year 3	31
Year 4	31
Year 5	31

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):*

Individuals with level of care I or VIII residing in or at imminent risk of entering a nursing facility (PI)

Purpose *(describe):*

This Promoting Independence target group reserves capacity for individuals with level of care I or VIII residing in or at imminent risk of entering a nursing facility.

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	303
Year 2	303
Year 3	303
Year 4	303
Year 5	303

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):*

Individuals leaving a large intermediate care facility for individuals with an intellectual disability or related condition, including a state supported living center (PI)

Purpose *(describe):*

This Promoting Independence target group reserves capacity for individuals leaving a large intermediate care facility for individuals with an intellectual disability or related conditions, including a state supported living center.

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	131
Year 2	131
Year 3	131
Year 4	131
Year 5	131

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):*

Individuals at risk of imminent institutionalization

Purpose *(describe):*

This target group reserves capacity for individuals who are at imminent risk of institutionalization. These individuals do not have to be on the HCS interest list and will receive a diversion slot.

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	250
Year 2	250
Year 3	250
Year 4	250
Year 5	250

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):*

Individuals who previously moved from a state supported living center to a community Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition

Purpose *(describe):*

This target group reserves capacity for individuals who moved from a state supported living center into a community intermediate care facility for individuals with intellectual disability or related condition and choose to enter into the HCS waiver within three years of their community placement from the state supported living center.

Describe how the amount of reserved capacity was determined:

The State reserves capacity for this target group in accordance with direction from the HHSC Commissioner using historical data of discharges from state supported living centers.

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

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

Appendix B: Participant Access and Eligibility

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

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

Individuals leaving a state hospital

Purpose *(describe):*

This target group reserves capacity for individuals who have chosen waiver services at the time of their discharge from a multiple disabilities unit of a state hospital operated by the HHSC. A vacancy resulting from the discharge of an individual in this target group may be filled only by a member of this target group.

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	0
Year 2	0
Year 3	0
Year 4	0
Year 5	0

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):*

Individuals currently residing in an Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition scheduled for closure (PI)

Purpose *(describe):*

This Promoting Independence target group reserves capacity for individuals receiving services in an institutional community-based program that is scheduled for closure. This target group also includes closures of Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Condition settings that result in individuals moving into HCS using Promoting Independence funds.

Describe how the amount of reserved capacity was determined:

The State reserves capacity for this target group as situations of need become existent.

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

Waiver Year	Capacity Reserved
Year 1	0
Year 2	0
Year 3	0
Year 4	0
Year 5	0

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):*

Individuals at risk of institutionalization in a state supported living center

Purpose *(describe):*

This target group is for individuals at risk of institutionalization in a state supported living center. The individuals do not have to be on the HCS interest list and will receive a diversion slot.

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	0
Year 2	0
Year 3	0
Year 4	0
Year 5	0

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 in conservatorship leaving a general residential operation

Purpose *(describe):*

This target group reserves capacity for children under the age of 18 with intellectual disabilities in the Department of Family and Protective Services conservatorship leaving a general residential operation.

Describe how the amount of reserved capacity was determined:

The Promoting Independence Advisory Committee recommended that the State set aside waiver slots for children in general residential operation.

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

Waiver Year	Capacity Reserved
Year 1	0
Year 2	0
Year 3	0
Year 4	0
Year 5	0

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):*

Individuals leaving state conservatorship

Purpose *(describe):*

This target group reserves capacity for children aging out of the State's conservatorship who qualify for HCS services.

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	100
Year 2	100
Year 3	100
Year 4	100
Year 5	100

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

When appropriations do not support demand, all individuals who are seeking waiver services are placed on an interest list. Each local intellectual and developmental disability authority interest list is automatically merged into a statewide interest list and is sorted by order of request date in the HHSC data system. Documentation is maintained in the statewide interest list of the specific local intellectual and developmental disability authority that registered each applicant. Offers of waiver enrollment are released by Health and Human Services Commission (HHSC) to the local intellectual and developmental disability authorities that registered the applicants based on the oldest request date on the statewide interest list. HHSC notifies a local intellectual and developmental disability authority, in writing, of a waiver vacancy and directs the local intellectual and developmental disability authority to offer the vacancy to the applicant. If an individual seeking entrance into HCS meets the criteria for one of the reserved capacity groups they bypass the interest list as long as there are reserved waiver capacity slots available.

Military family members will not be removed from the HCS interest list for temporarily moving outside of the state of Texas due to the military member's assignment. If an applicant who is a military family member is offered enrollment while temporarily living outside of Texas they shall retain their position on the interest list for up to one year after their family's military service ends.

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

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

2. Miller Trust State.

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

- ( ) **No**
- (●) **Yes**

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

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

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

Select one:

- ( ) **100% of the Federal poverty level (FPL)**

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

Specify percentage:

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

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

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

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

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

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

☒ **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:

The State had listed both the Code of Federal Regulations and the Social Security Act references for this eligibility group. This was a cleanup of federal references and terminology but this change did not remove any eligibility groups included in the waiver.

References are to the Social Security Act or the Code of Federal Regulations.

• Adoption Assistance and Foster Care Children: §1902(a)(10)(A)(i)(I), §473(b)(3), 42 CFR §435.145
• Children with Non-IV-E Adoption Assistance: §1902(a)(10)(A)(ii)(VIII); 42 CFR §435.227
• Coverage Infants and Children under age 19: §1902(a)(10)(A)(i)(III), (IV), (VI), and (VII); §1902(a)(10)(A)(ii)(IV) and (IX); §1931(b) and (d); 42 CFR §435.118
• Deemed Newborn Children: §1902(e)(4); §2112 (e); 42 CFR §435.117
• Disabled Adult Children (DAC): §1634(c), §1939(a)(2)(D)
• Disabled Widows(er): §1939(a)(2)(C); §1634(b); 42 CFR §435.137
• Early Aged Widow(er): §1634(d), §1939, 42 CFR §435.138
• Earnings Transitional Medical Assistance: §1902(e)(1)(A), §1925, 42 CFR §435.112
• Former Foster Care Children: §1902(a)(10)(A)(i)(IX), 42 CFR §435.150
• Independent Foster Care Adolescents; Medicaid for Transitioning Foster Care Youth: §1902(a)(10)(A)(ii)(XVII); 42 CFR §435.226
• Parents and Caretaker Relatives: §1931(b) and (d), 42 CFR §435.110
• Pickle Group: §1939(a)(5)(E), 42 CFR §435.135
• Pregnant Woman: §1902(a)(10)(A)(i)(III) and (IV); §1902(a)(10)(A)(ii)(I), (IV), and (IX); §1931(b) and (d); 42 CFR §435.116
• Reasonable Classification Children Under 21: §1902(a)(10)(A)(ii)(I) and (IV), 42 CFR §435.222
• Spousal Support Transitional: §1902(a)(10)(A)(i)(I), 42 CFR §435.115(f)

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 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 (3 of 7)

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:
- ○ **Other**

  Specify:

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

Select one:

- ◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

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

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

Select one:

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

◉ **The state does not establish reasonable limits.**

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

- ◉ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ○ **By 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:

The educational/professional qualifications of persons performing initial evaluations of level of care for applicants enrolling in the waiver are:

- Registered Nurse licensed by the State,
- Licensed Social Worker,
- Psychologist,
- Psychological Associate, or
- Qualified Intellectual Disability Professional as defined in Title 42 of the Code of Federal Regulations, Section 483.430(a).

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

The required Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition level of care I is defined in Title 26 of the Texas Administrative Code, Chapter 261, as follows:

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

(1) Meet the following criteria:

(a) Have a full scale intelligence quotient (IQ) score of 69 or below, obtained by administering a standardized individual intelligence test performed in accordance with program rule; or

(b) Have a full scale IQ score of 75 or below, obtained by administering a standardized individual intelligence test performed in accordance with program rule, and have a primary diagnosis by a licensed physician of a related condition that is included on the HHSC Approved Diagnostic Codes for Persons with Related Conditions, available at this link: https://www.hhs.texas.gov/handbooks/home-community-based-services-handbook/appendix-x-approved-diagnostic-codes-persons-related-conditions-list; and

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

If it is difficult or not possible to obtain a level of care determination for an applicant or individual using the standard testing methods, these alternative evaluation options may be utilized:

1. If a person has a sensory or motor deficit for which a specially standardized intelligence test or a certain portion of a standardized intelligence test is appropriate, the appropriate score should be used.
2. If a full-scale IQ score cannot be obtained from a standardized intelligence test due to age, functioning level, or other severe limitations, an estimate of a person's intellectual functioning should be documented with clinical justification. The level of care is assigned based on information submitted electronically by the local intellectual and developmental disability authorities providing service coordination to the individual via the HHSC data system utilizing the Intellectual Disability/Related Condition Assessment. The Intellectual Disability/Related Condition Assessment includes all factors that are assessed in evaluating a level of care determination: diagnostic information that includes age of onset of the condition, results of standardized intelligence testing, and assessments of adaptive behavior; measures from the Inventory for Client and Agency Planning; behavioral status; and information regarding day services.

The required Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition level of care VIII is defined in Title 26 of the Texas Administrative Code, Part 1, Chapter 261, as follows:

To meet the level of care VIII criteria, an applicant or individual must:
(1) have a primary diagnosis by a licensed physician of a related condition that is included on the HHSC Approved Diagnostic Codes for Persons with Related Conditions, available at this link: https://www.hhs.texas.gov/handbooks/home-community-based-services-handbook/appendix-x-approved-diagnostic-codes-persons-related-conditions-list; and
(2) have an adaptive behavior level of II, III, or IV (i.e., moderate to extreme deficits in adaptive behavior) obtained by administering a standardized assessment of adaptive behavior.

Individuals with a level of care VIII can only enter the waiver through the reserve capacity group "Individuals with level of care I or VIII residing in a nursing facility." Individuals with a level of care VIII were initially enrolled into the HCS waiver based upon a past legislative mandate requiring the State to serve individuals with a level of care VIII who chose waiver services. Title 7 of the Texas Health and Safety code Subtitle A, §533.0355, added by House Bill 2292 of the 78th Legislature, redefined the responsibilities of local intellectual and developmental disability authority program in a manner that resembles the HCS waiver. In order for the State to comply with the statutory requirements, the State proposed amendments that permitted individuals receiving local intellectual and developmental disability authority program services to continue to receive services under the HCS waiver and consolidated the HCS-O (HCS-Ombudsman Reconciliation Act of 1990) with the HCS waiver effective September 1, 2003. Individuals with a level of care VIII who were previously served in the HCS-O program were offered services in the HCS waiver at that time. The State continues to serve individuals in HCS who were enrolled as a result of this merger.

Adaptive behavior assessments (Vineland Adaptive Behavior Scales [VABS], AAMD Adaptive Behavior Scales [AAMD

ABS], Inventory for Client and Agency Planning and other standardized instruments) are used in conjunction with professional judgment to determine adaptive behavior levels. These are typically completed by professionals in the field of psychology, but may also be completed by other professionals as listed above. The Inventory for Client and Agency Planning, which is also used by Texas to determine level of need and funding allocations for certain services, may also be administered by non-professional staff, as indicated in the Inventory for Client and Agency Planning instruction manual.

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

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

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

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

The service coordinator, employed by the local intellectual and developmental disability authority, completes the initial Intellectual Disability/Related Condition Assessment form using the results of the evaluations performed by qualified professionals. The service coordinator requests an initial level of care determination for an applicant by electronically submitting the initial Intellectual Disability/Related Condition Assessment, via the HHSC data system, indicating the recommended initial level of care. The local intellectual and developmental disability authority maintains the initial signed Intellectual Disability/Related Condition Assessment and documentation supporting the recommended level of care in the applicant's record. Once the enrollment process is complete the provider agency is responsible for completing the Intellectual Disability/Related Condition Assessment annually or when an individual's needs change significantly requiring the level of care to be reevaluated and recommending a level of care. However if the individual has selected the consumer directed services option, the service coordinator maintains responsibility for completing the Intellectual Disability/Related Condition assessment. In these situations the service coordinator maintains the responsibility of completing the Intellectual Disability/Related Condition Assessment annually or when an individual's needs change significantly requiring the level of care to be reevaluated and recommending a level of care. The provider agency must maintain the signed Intellectual Disability/Related Condition Assessment and documentation supporting the recommended level of care in the individual's record. The service coordinator must also keep a copy of the Intellectual Disability/Related Condition Assessment. For all re-determinations of an individual's level of care, the service coordinator at the local intellectual and developmental disability authority reviews the assessment and the recommended level of care for agreement or disagreement. The service coordinator documents agreement or disagreement in the HHSC data system prior to the recommendation being transmitted to HHSC. If a service coordinator disagrees with an individual's recommended level of care, the service coordinator must notify, in writing, the individual, the provider agency, and HHSC of the reason for the disagreement.

A level of care determination must be made by HHSC in accordance with criteria specified in Section D of this Appendix and is assigned based on information submitted electronically via the HHSC data system utilizing the Intellectual Disability/Related Condition Assessment. Information on the Intellectual Disability/Related Condition Assessment must be supported by current data obtained from standardized evaluations and formal assessments that measure physical, emotional, social, and cognitive factors. The electronically transmitted Intellectual Disability/Related Condition Assessment must contain information identical to that on the signed Intellectual Disability/Related Condition Assessment. HHSC authorizes the recommended level of care in the HHSC data system or denies the recommended level of care and sends written notification to the service coordinator or provider agency that a level of care has been denied. Because denial of the recommended level of care results in denial of request for eligibility, HHSC also sends written notification to the applicant/individual, indicating the right to a fair hearing and the process to follow to request a fair hearing. The procedures for a fair hearing are provided in Appendix F of this waiver application.

A level of care determination is valid for 364 calendar days after the level of care effective date determined by HHSC.

If an individual is denied waiver enrollment based on diagnosis, level of care, or other functional eligibility requirements, a HHSC representative notifies the individual that his or her name will be placed on one or more other waivers interest list, using his or her original interest list request date unless the individual opts out of this option.

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

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:

Reevaluations of level of care are conducted at least annually and when an individual's needs change significantly and require that level of care be reevaluated. The Inventory for Client and Agency Planning, which is used by the State to determine level of need and funding allocations for certain services and is based on the individual's current functioning level, is administered by non-professional staff, as indicated in the Inventory for Client and Agency Planning instruction manual. If the individual's health condition changes and there is a demonstrated need to revise the current service plan, a reevaluation would be conducted and the service plan revised to reflect the current situation of the individual. If an individual's level of need decreases to the lowest level (level of need 1), HHSC requires the local intellectual and developmental disability authority to complete a new determination of intellectual disability and Intellectual Disability/Related Condition Assessment with a recommendation for a level of care. HHSC will review the determination of intellectual disability report, supporting documentation, Intellectual Disability/Related Condition Assessment, and level of care recommendation. HHSC authorizes the recommended level of care in the HHSC data system or denies the recommended level of care. If denied, the individual and service coordinator are notified of the individual's right to appeal the decision.

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:

The educational/professional qualifications of persons performing re-evaluations of level of care for waiver individuals are:

- Registered Nurse licensed by the State,
- Licensed Social Worker,
- Psychologist,
- Psychological Associate, or
- Qualified Intellectual Disability Professional as defined in Title 42 of the Code of Federal Regulations, Section 483.430(a).
- A person who has a minimum of three years work experience in planning and providing direct services to people with an intellectual disability or another developmental disability as verified by written professional references to oversee the provision of direct services to individuals.

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

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

- Edits in the automated HHSC data system;
- Annual reviews of local intellectual and developmental disability authorities to determine whether reevaluations occur in a timely manner; and
- Annual reviews of provider agencies.

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 in the HHSC data system are kept indefinitely, beginning from the time of enrollment. Paper copies of level of care are kept for seven years by the local intellectual and developmental disability authority for initial enrollment and by HHSC for records which are reviewed.

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 applicants who accepted an offer to participate in the enrollment eligibility process and received a level of care evaluation. N: Number of applicants who accepted an offer to participate in the enrollment eligibility process and received a level of care evaluation. D: Number of applicants who accepted an offer to participate in the enrollment eligibility process.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Assurance and Improvement Data Mart

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

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The 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.

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 new enrollees with initial LOCs completed prior to receipt of first service using approved processes and instruments. N: Number of new enrollees with initial LOCs completed prior to receipt of first service using approved processes and instruments. D: Number of new enrollees requiring initial LOC determinations who received at least one service.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Assurance and Improvement Data Mart

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

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

Data Aggregation and Analysis:

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

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.

All level of care redeterminations are ultimately submitted through and approved by the HHSC data system. This system contains edits that flag any level of care redetermination submission that contains a change in primary diagnosis, date of onset, or IQ score. A report is generated from the HHSC data system that identifies level of care redeterminations that include any of these changes. For redeterminations, HHSC reviews the Intellectual Disability/Related Condition assessment and appropriate documentation to ensure the level of care is appropriate. Additionally, the HHSC data system tracks level of care history of individuals and level of care denials system-wide.

One hundred percent of initial level of care determinations are reviewed by HHSC staff that is qualified as a Registered Nurse, licensed social worker, or qualified intellectual disability professional to ensure that the processes and instruments have been applied correctly to determine the individual's level of care. The HHSC psychologist also reviews the initial Intellectual Disability/Related Condition Assessment and appropriate documentation to verify that the individual meets the level of care criteria for the waiver prior to enrollment.

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.

The service coordinator at the local intellectual and developmental disability authority is responsible for monitoring the individual's needs and service plan at least every 90 days. If a service coordinator or provider agency determine that an individual's needs change significantly, a new level of care assessment must be completed. At least annually and as an individual's needs change significantly, the provider agency is responsible for reviewing the individual's level of care. The service coordinator performs the new level of care assessment and the local intellectual and developmental disability authority enters it into the HHSC data system for HHSC determination of the level of care. HHSC Long-Term Care Regulation conducts annual reviews of all provider agencies and HHSC Contract Accountability and Oversight unit conducts annual reviews of all local intellectual and developmental disability authorities.

The HHSC data system produces daily reports of all pending level of care determinations. This report is used to initiate reviews of all pending levels of care. The HHSC data system prevents billing for services provided prior to HHSC's authorization of level of care. If a level of care is not approved, the individual and the local intellectual and developmental disability authority service coordinator receives the denial including the right to a fair hearing to appeal the decision. The service coordinator works with the individual and the individual's natural supports to assist with linkage to non-waiver services and supports. The information is communicated immediately upon that determination to the local intellectual and developmental disability authority and the individual is supported by the local intellectual and developmental disability authority service coordinator to obtain non-waiver supports as required.

HHSC conducts monthly scan calls with the local intellectual and developmental disability authorities to provide technical assistance and updated information, including assistance and information related to level of care processes. HHSC offers technical assistance to provider agencies and service coordinators through webinars as well as on a day-to-day basis through the Program Enrollment Support unit on eligibility and level of care information. HHSC offers daily technical assistance to provider agencies and service coordinators on level of need and plan of care changes through the Utilization Review unit. HHSC also updates the waiver manual as needed and conducts a training session regarding the level of care process for service coordinators and Qualified Intellectual Disabilities Professionals during each annual conference for intermediate care facility for individuals with an intellectual disability or related condition service providers.

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**

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

A local intellectual and developmental disability authority staff member presents the applicant with program information for both the HCS waiver and intermediate care facilities for individuals with an intellectual disability or related condition. The Verification of Freedom of Choice form is presented and reviewed with the individual by the local intellectual and developmental disability authority staff member at the time of enrollment. Following the presentation of this information, the staff member offers the applicant the opportunity to make an informed choice between the two programs and documents the applicant's decision to accept or refuse the offer of waiver services on the Verification of Freedom of Choice form at enrollment. At the annual service planning team meeting, the local intellectual and developmental disability authority service coordinator informs the individual that they have a right to choose among any certified provider agency at any time and offers information about services available through the consumer directed services option.

Service coordinators give individuals a complete listing of qualified provider agencies and, for individuals residing in their own home or family home receiving supported home living, respite, nursing, employment assistance, supported employment, cognitive rehabilitation therapy, or community first choice (CFC) personal assistance services/habilitation (PAS)/(HAB), provide information about the consumer directed services option upon enrollment and at any time upon request. An individual in the HCS waiver may select any qualified contracted provider agencies to furnish waiver services or may choose to self-direct some or all of their applicable services through the consumer directed services option. The Texas Administrative Code requires the provider agency to serve an eligible applicant who has selected the provider agency unless the provider agency's enrollment has reached its service capacity or if the individual is self-directing all of their services. If a provider agency that had not reached its service capacity declined to serve an individual who had selected the provider agency, the State would handle the provider agency's denial of choice through the complaint process. Complaints are reported directly to the HHSC Intellectual and Developmental Disability Ombudsman (IDD Ombudsman), which assigns an ombudsman for follow-up investigation of the complaint. The follow-up investigation by the IDD Ombudsman may result in a referral to HHSC Long-Term Care Regulation division for further investigation and monitoring.

HHSC Communications Office, Language Services Unit coordinates translations for HHSC. HHSC routinely provides Spanish translation of forms and letters and is responsive to other translation needs. Local intellectual and developmental disability authority service coordinators and provider agencies must ensure that interpreter services are available, if needed, to individuals during service planning and service delivery.

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 intellectual and developmental disability authority retains the Verification of Freedom of Choice form in the applicant's record for seven years. HHSC maintains these forms for five years in the HHSC data system.

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):

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

The HHSC Communications Office, Language Services Unit provides the following: translating written materials from English to Spanish and vice versa for state office and the regions; review and evaluation of Spanish translations that were prepared elsewhere; proofreading translated copy to ensure accuracy; translating correspondence sent by individuals to state office; providing voice talent for audio and video productions; coordinating translation and interpretation for languages other than Spanish.

The service coordinator meets with the individual to explain the necessary forms and information to the individual. Regardless of the language spoken by an individual, the local intellectual and developmental disability authority must enroll an eligible individual within the timeframes according to policy and must ensure that interpreter services are available to individuals, if needed. Other than Spanish, no other languages are routinely presented. If other languages are required, the local intellectual and developmental disability authority coordinates translation on a local level on an individual basis.

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	**Individualized Skills and Socialization**
Statutory Service	**Respite**
Statutory Service	**Supported Employment**
Extended State Plan Service	**Adaptive Aids**
Extended State Plan Service	**Audiology**
Extended State Plan Service	**Occupational Therapy**
Extended State Plan Service	**Physical Therapy**
Extended State Plan Service	**Prescribed Drugs**
Extended State Plan Service	**Speech and Language Pathology**
Supports for Participant Direction	**Financial Management Services**
Supports for Participant Direction	**Support Consultation**
Other Service	**Behavioral Support**
Other Service	**Cognitive Rehabilitation Therapy**
Other Service	**Dental Treatment**
Other Service	**Dietary Services**
Other Service	**Employment Assistance**
Other Service	**Minor Home Modifications**
Other Service	**Nursing**
Other Service	**Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services)**
Other Service	**Social Work**
Other Service	**Supported Home Living**
Other Service	**Transition Assistance Services**

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Individualized Skills and Socialization

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

The individualized skills and socialization service component provides person-centered activities related to acquiring, retaining, or improving self-help skills and adaptive skills necessary to live successfully in the community and participate in home and community life, and gaining or maintaining greater independence, socialization, community participation, current or future volunteer goals or employment goals consistent with achieving the outcomes identified in an individual's person-directed plan. Individualized skills and socialization supports the individual's pursuit and achievement of employment through school, vocational rehabilitation, the HCS service of employment assistance, or the HCS service of supported employment. Individualized skills and socialization provides personal assistance for an individual who cannot manage personal care needs during an individualized skills and socialization activity and, as determined by an assessment conducted by a registered nurse, provides assistance with medications and the performance of tasks delegated by a registered nurse in accordance with state law and rules, unless a physician has delegated the task as a medical act under Texas Occupations Code, Chapter 157, as documented by the physician.

Individualized skills and socialization can be provided on site or off site in settings described in the Texas Administrative Code, Title 26, Part 1, Chapter 263, Subchapter L.

Off-site individualized skills and socialization will provide activities that integrate the individual into the community and that promote the individual's development of skills and behavior that support independence and personal choice. Off-site individualized skills and socialization will be provided in a community setting chosen by the individual from among community setting options.

Individualized skills and socialization will be furnished in accordance with the individual's person directed plan, individual plan of care, and implementation plan.

Individualized skills and socialization will provide transportation necessary for the individual's participation in off-site individualized skills and socialization.

HHSC confirms that the settings where Individualized Skills and Socialization is provided meets the requirements of the HCBS Settings Rule.

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

The service limit for the combined total of individualized skills and socialization service components are:

1) 1,560 hours per individual plan of care year;
2) Six hours per calendar day; and
3) Five days per calendar week.

Individualized skills and socialization may not be provided to an individual at the same time as supported home living.

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	Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Individualized Skills and Socialization

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

The individualized skills and socialization service provider will be licensed in accordance with Title 26 TAC 559.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Employee Requirements:
The service provider of the individualized skills and socialization service must be at least 18 years of age. The individual's legally authorized representative can be the service provider if they are not the parent of a minor or the spouse of the minor's parent. The service provider must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served, as demonstrated through a written competency-based assessment and at least three personal references from persons not related by blood that indicate the ability to provide a safe and healthy environment for the individual(s) to be served.

A service provider who provides transportation must have a valid driver's license and transport individuals in a vehicle insured in accordance with state law.

Assistance with tasks delegated by a Registered Nurse must be provided in accordance with applicable state law, program rules, and policies. The service provider of individualized skills and socialization must complete initial and periodic training in accordance with 40 Texas Administrative Code §9.177 (relating to Certification Principles: Staff Member and Service Provider Requirements).

Verification of Provider Qualifications

Entity Responsible for Verification:

HHSC
Provider agency

Frequency of Verification:

The provider agency will verify the individualized skills and socialization provider qualifications prior to hiring. HHSC will verify provider agency and service provider qualifications during initial certification and recertification surveys.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

The respite service component is provided for the planned or emergency short-term relief of the unpaid primary caregiver of an individual who has the same residence as the individual. Respite is provided intermittently when the unpaid primary caregiver is temporarily unavailable to provide supports. This service provides an individual with personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of behavioral support or specialized therapies activities; assisting an individual with administration of certain medications or with supervision of self-medication in accordance with the Texas Board of Nursing rules as defined by Title 22 of the Texas Administrative Code, Part 11, Chapter 225; and supervision as needed to ensure the individual's health and safety.

This service includes habilitation activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills.

Respite must be provided to an individual in a setting that is not the individual's residence. The settings in which respite may be provided are as follows:
(1) a camp accredited by the American Camp Association;
(2) a respite facility;
(3) the residence of another person:
(A) a three-person residence;
(B) a four-person residence; and
(C) a residence in which host home/companion care is provided.

In-home respite is provided in the residence of the individual or in other locations, including residences in which supervised living or residential support is provided, camps or in a respite facility that meets HCS waiver requirements and afford an environment that ensures the health, safety, comfort, and welfare of the individual. The service provider of respite must ensure that respite is provided in accordance with the individual's service plan and implementation plan, and with Appendix C of the HCS waiver application approved by CMS.

Transportation costs associated with the respite service are included in the respite rate. Transportation to and from the respite service site is not a billable service for the respite service but is included in the billable service for supported home living.

Examples of approvable routine, intermittent circumstances for which respite may be used include, but are not limited to:
- caregiver attending church when the individual does not want to attend;
- caregiver attending counseling appointments; or
- weekly outing for caregiver and spouse.

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

Reimbursement is limited to 300 hours annually for respite and in-home respite combined. Respite is not a reimbursable service for individuals receiving host home/companion care, supervised living, or residential support.

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

Each 24-hour day of respite is paid at the rate of 10 hours of in-home respite. If necessary, an individual's local intellectual and developmental disability authority service coordinator or program provider assists the individual in locating additional resources through family or local community organizations, and other natural supports.

Respite cannot be provided in an institution such as a nursing facility, intermediate care facility for individuals with intellectual disabilities, or a hospital.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding an HCS Medicaid service provider agreement
Individual	Consumer directed services direct service provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Agencies holding an HCS Medicaid service provider agreement

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by HHSC as an HCS service provider

Other Standard *(specify):*

Employee requirements:

The service provider of in-home respite and respite must be at least 18 years of age. The service provider may be an employee or under contract with the provider agency; must have a high school diploma or Certificate of High School Equivalency (General Equivalency Diploma credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served as demonstrated through a written competency-based assessment; and at least three personal references from persons not related by blood that evidence the ability to provide a safe and healthy environment for the individual(s) to be served.

Camps must be accredited by the American Camp Association.

The Registered Nurse must assess the competency of any service provider to supervise an individual's self-administration of medication or the competency of the service provider to receive delegation. Title 22 of the Texas Administrative Code, Part 11, Chapter 225, §225.10 specifies the Board of Nursing requirements for delegation and specifies the tasks which may be delegated and tasks which do not require delegation. Registered Nurses must adhere to the Board of Nursing requirements regarding delegation.

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

Assisting with tasks delegated by a Registered Nurse must be in accordance with state law, program rules, and policies.

The service provider of respite must not live with the individual.

Title 40 of the Texas Administrative Code, Chapter 9, Part 1, Subchapter D specifies that service providers must be knowledgeable about the individual needs of each individual served and be knowledgeable about what constitutes abuse, neglect, and exploitation and how to report abuse, neglect, and exploitation. Frequency of periodic training is not prescribed, but must ensure that service providers can demonstrate this knowledge during Long-Term Care Regulation reviews.

The service provider of respite must complete initial and periodic training provided by the provider agency in accordance with Title 40 of the Texas Administrative Code, Part 1, Subchapter D, §9.177.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCS provider agency

HHSC

Frequency of Verification:

The provider agency verifies service provider qualifications prior to hiring.

HHSC verifies provider agency qualifications during surveys.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

The service provider for both the in-home and respite service component must be at least 18 years of age.

The service provider must be an employee of the employer; have a high school diploma or Certificate of High School Equivalency (General Equivalency Diploma credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served as demonstrated through a written competency-based assessment; and at least three personal references from persons not related by blood that evidence the ability to provide a safe and healthy environment for the individual(s) to be served.

Respite can be used to attend camp. Camps must be accredited by the American Camp Association.

The Registered Nurse must assess the competency of any service provider to supervise an individual's self-administration of medication or the competency of the service provider to receive delegation. Title 22 of the Texas Administrative Code, Part 11, Chapter 225, §225.10 specifies the Board of Nursing requirements for delegation and specifies the tasks which may be delegated and tasks which do not require delegation. Registered Nurses must adhere to the Board of Nursing requirements regarding delegation.

Title 40 of the Texas Administrative Code, Chapter 9, Part 1, Subchapter D specifies that service providers must be knowledgeable about the individual needs of each individual served and be knowledgeable about what constitutes abuse, neglect, and exploitation and how to report abuse, neglect, and exploitation. Frequency of periodic training is not prescribed.

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

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

The service provider of respite must not live with the individual. The individual's guardian, designated representative, or spouse of the designated representative may not be the service provider of respite services for the individual.

An individual employer and financial management services agency are both required by 40 Texas Administrative Code Chapter 41 Consumer Directed Services Option to verify that a service provider meets the qualifications required by the individual's program rules before being hired. The FMSA is required to retain documentation on file if the applicant is hired or retained by the employer or DR for service delivery. The employer is required to obtain and retain documentation on file that a service provider continues to meet the qualifications required by the individual's program rules, policies, and manuals, and other state and federal regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer and financial management services agency

HHSC

Frequency of Verification:

Individual/employer and financial management services agency will ensure staff or contractor is qualified prior to hiring or contracting with the service provider and on an ongoing basis.

HHSC during on-site and desk reviews conducted at a minimum every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
03 Supported Employment	03022 ongoing supported employment, group
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

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

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.

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

In the state of Texas, this service is not available to individuals 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.).

This service may not be provided to the individual with the individual present at the same time that individualized skills and socialization, supported home living, employment assistance, face to face state plan Community First Choice Personal Assistant Services/ Habilitation, or respite is provided.

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
Individual	Consumer directed services direct service provider
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Individual
Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The supported employment service provider must be at least 18 years of age and meet one of the following qualifications:
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 employment services to people with disabilities;

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

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

The service provider may not be the individual's spouse or the parent of the individual if the individual is a minor.

An individual employer and financial management services agency are both required by 40 Texas Administrative Code Chapter 41 Consumer Directed Services Option to verify that a service provider meets the qualifications required by the individual's program rules before being hired. The FMSA is required to retain documentation on file if the applicant is hired or retained by the employer or DR for service delivery. The employer is required to obtain and retain documentation on file that a service provider continues to meet the qualifications required by the individual's program rules, policies, and manuals, and other state and federal regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer
Financial management services agency
HHSC

Frequency of Verification:

Individual/employer and financial management services agency will ensure staff or contractor is qualified prior to hiring or contracting with the service provider and on an ongoing basis.
HHSC during on-site and desk reviews conducted a minimum of every three years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Agencies holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by HHSC as an HCS provider agency

Other Standard *(specify):*

The supported employment service provider must be at least 18 years of age and meet one of the following qualifications:
Option 1:
- have a bachelor's degree in rehabilitation, business, marketing, or a related human services field and at least six months paid or unpaid experience providing employment services to people with disabilities;

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

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

The service provider may not be the individual's spouse or parent of the individual if the individual is a minor.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCS provider agency and HHSC

Frequency of Verification:

The provider agency verifies service provider qualifications prior to hiring.

HHSC verifies provider agency qualifications during initial certification and recertification surveys.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Adaptive Aids

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 3:	**Sub-Category 3:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

This service provides devices, controls, appliances, or items that are necessary to address specific needs identified by the individual's service plan. Adaptive aids enable individuals to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live.

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

An adaptive aid is provided for a specific individual and becomes the exclusive property of that individual.

Adaptive aids are limited to the following categories including repair and maintenance not covered by warranty:
(A) Lifts, including vehicle lifts
(B) Mobility Aids
(C) Positioning Devices
(D) Control switches/pneumatic switches and devices
(E) Environmental control units
(F) Medically necessary supplies
(G) Communication aids (including batteries)
(H) Adaptive/modified equipment for activities of daily living
(I) Safety restraints and safety devices

Excluded are those items and supplies, which are not of direct medical or remedial benefit to the individual and items and supplies that are available to the individual through the Medicaid State Plan, through other governmental programs, or through private insurance.

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

Any item or service not listed in Appendix VII of the HCS Billing Guidelines, Billable Adaptive Aids, is not billable as an adaptive aid.

Adaptive aids may not exceed $10,000 per service plan year and is subject to the individual total annual service cost limit of the waiver.

Adaptive aids are provided under this waiver when no other financial resource for such aids is available or when other available resources have been used. Individuals who are under 21 years of age must access benefits through the Texas Health Steps--Comprehensive Care Program before adaptive aids may be provided under 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. The provider agency must obtain one of the following as proof of non-coverage by Medicaid:

A letter from Texas Medicaid & Healthcare Partnership that includes a statement that the requested adaptive aid is denied under the Texas Medicaid Home Health Services or the Texas Health Steps programs; and the reason for the denial, which must not be one of the following: Medicare is the primary source of coverage; information submitted to TMHP to make payment was incomplete, missing, insufficient or incorrect; the request was not made in a timely manner; or the adaptive aid must be leased;

A letter from Texas Medicaid & Healthcare Partnership stating that the adaptive aid is approved and the amount to be paid, which must be less than the cost of the requested adaptive aid; or

A provision from the current Texas Medicaid Providers Procedure Manual stating that the requested adaptive aid is not covered by the Texas Medicaid Home Health Services or the Texas Health Steps programs.

The individual and provider agency must agree on the necessity of all adaptive aids. All adaptive aids must be agreed upon by the individual and provider agency based upon written evaluations and recommendations by the individual's physician, a licensed occupational or physical therapist, a service provider of behavioral support, a licensed nurse, a licensed dietician, a licensed optometrist, a therapeutic optometrist, a licensed audiologist, or a speech/language pathologist qualified to assess the individual's need for the specific adaptive aid as specified in Appendix VII of the HCS Billing Requirements. The written evaluation and recommendation must document the necessity and appropriateness of the adaptive aid to meet the specific needs of the individual. All proposed service plans, including proposed service plans that include the cost for adaptive aids, must be reviewed in the Client Assignment and Registration system by the local intellectual and developmental disability authority service coordinator, who agrees or disagrees with the service plan prior to the service plan being transmitted to HHSC. If the service coordinator disagrees with a proposed service plan, the service coordinator must indicate to HHSC, in writing, the reason for their disagreement.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Adaptive Aids

Provider Category:

Agency

Provider Type:

Agencies holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by HHSC as an HCS provider agency

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

HCS provider agency

HHSC

Frequency of Verification:

HCS service provider prior to completing service agreement with service provider.

HHSC during monitoring reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Audiology

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:

Category 4:

Sub-Category 4:

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

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

Service Definition *(Scope):*

Audiology provides assessment and treatment by licensed audiologist and includes:

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

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

Audiology is provided under this waiver when no other financial resource for such therapies is available or when other available resources have been used. Individuals who are under 21 years of age must first access benefits through the Texas Health Steps--Comprehensive Care Program (EPSDT) before audiology may be provided under this waiver. All medically necessary audiology services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Audiology

Provider Category:

Agency

Provider Type:

Agencies holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify):*

The audiologist must be licensed under Title 3 of the Texas Occupations Code, Subtitle G, Chapter 401.

Certificate *(specify):*

Certified by HHSC as HCS provider agency

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

HCS provider agency

HHSC

Frequency of Verification:

The provider agency verifies service provider qualifications prior to completing service agreement and prior to expiration of license.

HHSC verifies provider agency qualifications during initial certification and recertification surveys.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy

HCBS Taxonomy:

Category 1: 11 Other Health and Therapeutic Services

Sub-Category 1: 11080 occupational therapy

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition *(Scope):*

Occupational therapy provides assessment and treatment by licensed occupational therapist and includes:

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

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

Occupational therapy is provided under this waiver when no other financial resource for such therapies is available or when other available resources have been used. Individuals who are under 21 years of age must first access benefits through the Texas Health Steps--Comprehensive Care Program before occupational therapy may be provided under this waiver. All medically necessary occupational therapy services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Agencies holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify):*

The occupational therapist must be licensed under Title 3 of the Texas Occupations Code, Subtitle H, Chapter 454.

Certificate *(specify):*

Certified by HHSC as an HCS provider agency

Other Standard *(specify):*

The service provider cannot be the participant's spouse.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCS provider agency

HHSC

Frequency of Verification:

The provider agency verifies service provider qualifications prior to completing service agreement and prior to expiration of license.

HHSC verifies provider agency qualifications during initial certification and recertification surveys.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

HCBS Taxonomy:

Category 1: 11 Other Health and Therapeutic Services

Sub-Category 1: 11090 physical therapy

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition *(Scope):*

Physical therapy provides assessment and treatment by licensed physical therapist and includes:

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

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

Physical therapy services are provided under this waiver when no other financial resource for such therapies is available or when other available resources have been used. Individuals who are under 21 years of age must first access specialized therapy benefits through the Texas Health Steps--Comprehensive Care Program before specialized therapies may be provided under this waiver. All medically necessary physical therapy services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

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	Agency holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Agency holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify):*

The physical therapist must be licensed under Title 3 of the Texas Occupations Code, Subtitle H, Chapter 453.

Certificate *(specify):*

Certified by HHSC as an HCS provider agency

Other Standard *(specify):*

The service provider cannot be the participant's spouse.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCS provider agency

HHSC

Frequency of Verification:

The provider agency verifies service provider qualifications prior to completing service agreement and prior to expiration of license.

HHSC verifies provider agency qualifications during initial certification and recertification surveys.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Prescribed Drugs

HCBS Taxonomy:

Category 1: 11 Other Health and Therapeutic Services

Sub-Category 1: 11060 prescription drugs

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition *(Scope):*

Provides unlimited prescription medications to individuals enrolled in the waiver who are eligible for both Medicaid and Medicare (dually eligible). An individual who is dually eligible must obtain prescribed medications through the Medicare Prescription Drug Plan or, for certain medications excluded from Medicare, through the Texas Medicaid State Plan before medications are furnished under the waiver.

Individuals in the waiver who are enrolled in managed care for their acute care services receive unlimited prescription medications through their managed care and therefore do not qualify for prescriptions through the waiver. Dual eligible adults (21 and older) are excluded from enrollment into managed care and are still eligible for prescription medications through the waiver if they meet the requirements above.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Pharmacies holding a Medicaid provider agreement with HHSC

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Pharmacies holding a Medicaid provider agreement with HHSC

Provider Qualifications

License *(specify):*

The pharmacy must be licensed by the Texas State Board of Pharmacy under Title 22 of the Texas Administrative Code, Part 15, Chapter 291.

Certificate *(specify):*

Other Standard *(specify):*

Must hold a Medicaid service provider agreement with HHSC.

Verification of Provider Qualifications

Entity Responsible for Verification:

Texas State Board of Pharmacy

Frequency of Verification:

Biennially

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Speech and Language Pathology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

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

Service Definition *(Scope):*

Speech and language pathology provides assessment and treatment by licensed speech and language pathologists and includes:

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

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

Speech and language pathology services are provided under this waiver when no other financial resource for such therapies is available or when other available resources have been used. Individuals who are under 21 years of age must first access benefits through the Texas Health Steps--Comprehensive Care Program before speech and language pathology may be provided under this waiver. All medically necessary speech and language pathology services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech and Language Pathology

Provider Category:

Agency

Provider Type:

Agencies holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify):*

Licensed as a:
- speech-language pathologist in accordance with Title 3 of the Texas Occupations Code, Subtitle G, Chapter 401.
- licensed assistant in speech-language pathology in accordance with Chapter 401 of the Texas Occupations Code

Certificate *(specify):*

Certified by HHSC as an HCS provider agency

Other Standard *(specify):*

The service provider cannot be the participant's spouse.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCS provider agency

HHSC Long-Term Care Regulation

Frequency of Verification:

The provider agency verifies service provider qualifications prior to completing service agreement and prior to expiration of license.

HHSC verifies provider agency qualifications during initial certification and recertification surveys.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Financial management services provides assistance to individuals with managing funds associated with consumer directed services. The service includes initial orientation and ongoing training that is limited to budget development and management as well as the legal and programmatic requirements of being an employer. The financial management services provider, referred to as the financial management services agency also provides assistance in the development, monitoring, and revision of the individual's budget for each service delivered through the consumer directed services option and must maintain a separate account for each individual's budget. The financial management services agency provides assistance in determining staff wages and benefits subject to HHSC limits, assistance in hiring by verifying employee's citizenship status and qualifications, and conducting required background checks. The financial management services agency verifies and maintains documentation of employee qualifications, including citizenship status, and timesheets for services delivered. The financial management services agency also collects timesheets, processes timesheets of employees, processes payroll, withholding, filing and payment of applicable federal, state, and local employment-related taxes and insurance. The financial management services agency makes payments directly to the consumer directed services employee. The financial management services agency tracks disbursement of funds and provides periodic reports to the individual of all expenditures and the status of the individual's consumer directed services budget.

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

The financial management services agency must not provide other waiver services to the individual other than support consultation. The financial management services agency must not provide service coordination to the individual.

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	Financial management services agencies holding a Medicaid provider agreement

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Financial management services agencies holding a Medicaid provider agreement

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The financial management services agency must successfully complete a mandatory initial enrollment training and receive a score of at least 85% on a competency test to obtain a Medicaid provider agreement to provide financial management services. The rules for the consumer directed services option, located at Title 40 of the Texas Administrative Code, Part 1, Chapter 41, detail the responsibilities of an employer agent, including the revocation of IRS Form 2678 if the individual terminates the consumer directed services option or transfers to another financial management services agency.

The financial management services agency must attend periodic training conducted by HHSC. HHSC conducts monitoring reviews to assess compliance based on standards related to background checks, licensure verification, orientation of the consumer directed services employer, new hire process, employer budgets and expenditure reports, and payroll. If a financial management services agency scores less than 90% on a monitoring review, HHSC requires corrective action.

The financial management services agency service provider must be at least 18 years of age and must not be the individual's legal guardian, the spouse of the individual's legal guardian, the individual's designated representative, or the spouse of the individual's designated representative.

The financial management services agency must have support consultation services available.

Verification of Provider Qualifications

Entity Responsible for Verification:

HHSC

Frequency of Verification:

The FMSA verifies service provider qualifications prior to hiring. HHSC verifies provider qualifications were met prior to service delivery during reviews, completed every three years at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Support Consultation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Support consultation is an optional service that offers practical skills training and assistance to enable an individual or employer's designated representative to successfully direct those services the individual elect for consumer direction. This service is provided by a qualified support advisor, and includes skills training related to recruiting, screening, and hiring workers; preparing job descriptions; verifying employment eligibility and qualifications; completion of documents required to employ an individual; managing workers; and development of effective backup plans for services considered critical to the individual's health and welfare in the absence of the regular service provider or an emergency situation. Skills training involves such activities as training and coaching the employer regarding how to write an ad, how to interview potential job candidates, and role-play in preparation for interviewing potential employees. In addition, the support advisor assists the individual to determine staff duties, to orient and instruct staff in duties, and to schedule staff. Support advisors also assist the individual with activities related to the supervision of staff, the evaluation of the job performance of staff, and the discharge of staff when necessary. This service provides sufficient information and assistance to ensure that individuals and their representatives understand the responsibilities involved with consumer direction. Support consultation provides a level of training, assistance, and support that does not duplicate or replace the services delivered through Financial Management Services, service coordination, or other available program or non-program service or resources. Support consultation does not address budget, tax, or workforce policy issues. The State defines support consultation activities as the types of support provided beyond that provided by the financial management services agency. The scope and duration of support consultation will vary depending on an individual's need for support consultation.

Support consultation may be provided by a qualified support advisor associated with a financial management services agency selected by the individual/employer or by a qualified, independent support advisor hired by the individual/employer. Support consultation has a specific reimbursement rate and is a component of the individual's service budget. In conjunction with the individual's local intellectual and developmental disability authority service coordinator, individuals determine the level of support consultation necessary for inclusion in each individual's service plan.

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

The support advisor does not provide service coordination or any other waiver service except for financial management services to the individual.

The support advisor cannot be the individual's legal guardian; the spouse of the individual's legal guardian; the individual's designated representative; or the spouse of the individual's designated representative.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Individual service providers must have certification of successful completion of required training conducted or approved by HHSC.

Other Standard *(specify):*

A support advisor must be at least 18 years of age. The support advisor must have a high school diploma or Certificate of High School Equivalency (General Equivalency Diploma credentials); pass a criminal background check; complete initial training required by and conducted or authorized by HHSC and pass a competency test based on the initial training; and complete any ongoing training as required by HHSC.

Support consultation may be provided by a qualified support advisor associated with a financial management services agency selected by the individual, or by an independent support advisor hired by the individual.

The support advisor does not provide service coordination or any other waiver service except for financial management services to the individual.

The support advisor cannot be the individual's legal guardian; the spouse of the individual's legal guardian; the individual's designated representative; or the spouse of the individual's designated representative.

An individual employer and financial management services agency are both required by 40 Texas Administrative Code Chapter 41 Consumer Directed Services Option to verify that a service provider meets the qualifications required by the individual's program rules before being hired. A financial management services agency is required to obtain and retain documentation on file that a service provider continues to meet the qualifications required by the individual's program rules, policies, and manuals, and other state and federal regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer

financial management services agency

HHSC

Frequency of Verification:

The individual/employer and financial management services agency verify service provider qualifications prior to hiring.

HHSC verifies provider qualifications were met prior to service delivery during reviews, completed every three years at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavioral Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10010 mental health assessment
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Behavioral support service component provides specialized interventions that assist an individual to increase adaptive behaviors to replace or modify maladaptive or socially unacceptable behaviors that prevent or interfere with the individual’s inclusion in home and family life or community life. The component includes assessment and analysis of assessment findings of the behavior(s) to be targeted so that an appropriate behavioral support plan may be designed; development of an individualized behavioral support plan consistent with the outcomes identified in the individual's person-directed plan; training of and consultation with family members or other support service providers and, as appropriate, with the individual in the purpose/objectives, methods and documentation of the implementation of the behavioral support plan or revisions of the plan; monitoring and evaluation of the success of the behavioral support plan implementation; and modification, as necessary, of the behavioral support plan based on documented outcomes of the plan’s implementation.

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

Behavioral Support is provided under this waiver if no other financial resource for such service is available or if other available resources have been used.

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	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support

Provider Category:

Agency

Provider Type:

Agencies holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify):*

Licensed as a:
- Licensed Clinical Social Worker under Title 3 of the Texas Occupations Code, Subtitle I, Chapter 505;
- Psychologist under Title 3 of the Texas Occupations Code, Subtitle I, Chapter 501;
- Psychological Associate under Title 3 of the Texas Occupations Code, Subtitle I, Chapter 501;
- Licensed Professional Counselor under Title 3 of the Texas Occupations Code, Subtitle I, Chapter 503; or
- Behavior Analyst under Title 3 of the Texas Occupations Code, Subtitle I, Chapter 506.

Certificate *(specify):*

Or certified as a:
- HHSC-certified Psychologist in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 5, Subchapter D, Section 5.161;
- Behavior Analyst by the Behavior Analyst Certification Board, Inc.

Certified by HHSC as an HCS provider agency

Other Standard *(specify):*

Legally authorized representatives and persons related to the individual within the fourth degree of consanguinity or within the second degree of affinity may not provide behavioral support services for the individual.

Behavioral support providers must comply with requirements in Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D.

The behavioral support service provider must receive certain training prescribed by HHSC.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCS provider agency

HHSC

Frequency of Verification:

The provider agency verifies service provider qualifications prior to completing a service agreement and prior to execution of license or certification.

HHSC verifies provider agency qualifications during initial certification and recertification surveys.

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:

Cognitive Rehabilitation Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11120 cognitive rehabilitative therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Cognitive rehabilitation therapy is a service that assists an individual in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry in order to enable the individual to compensate for the lost cognitive functions. Cognitive rehabilitation therapy is provided when determined to be medically necessary through an assessment conducted by an appropriate professional. Cognitive rehabilitation therapy is provided in accordance with the plan of care developed by the assessor, and includes reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems.

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

The assessment is provided through the Medicaid State plan and is not included under this waiver.

The service provider may not be the individual's spouse, parent, primary caregiver, designated representative, legal guardian, or the spouse of the legal guardian, managing conservator, or persons related to the individual within the fourth degree of consanguinity or within the second degree of affinity.

This waiver service is only provided to individuals age 21 and over. Individuals under the age of 21 who are Medicaid eligible will continue to have access to appropriate therapy for learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry under the current Medicaid State Plan services through occupational therapists, speech-language pathologists, and psychologists pursuant to the EPSDT benefit.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer directed services direct service provider
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Rehabilitation Therapy

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

Psychologists licensed under Title 3 of the Texas Occupations Code, Subtitle I, Chapter 501.

Speech and language pathologists licensed under Title 3 of the Texas Occupations Code, Subtitle G, Chapter 401.
Occupational therapists licensed under Title 3 of the Texas Occupations Code, Subtitle H, Chapter 454.

Certificate *(specify):*

Other Standard *(specify):*

The service provider may not be the individual's spouse, parent, primary caregiver, designated representative, legal guardian or the spouse of the legal guardian, managing conservator, or persons related to the individual within the fourth degree of consanguinity or within the second degree of affinity.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer
Financial management services agency
HHSC

Frequency of Verification:

Individual/employer and financial management services agency verify service provider qualifications prior to hiring.

HHSC verifies provider qualifications were met prior to service delivery during reviews, completed every three years at a minimum.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Rehabilitation Therapy

Provider Category:

Agency

Provider Type:

Agencies holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify):*

Psychologists licensed under Title 3 of the Texas Occupations Code, Subtitle I, Chapter 501.

Speech and language pathologists licensed under Title 3 of the Texas Occupations Code, Subtitle G, Chapter 401.
Occupational therapists licensed under Title 3 of the Texas Occupations Code, Subtitle H, Chapter 454.

Certificate *(specify):*

Other Standard *(specify):*

The service provider may not be the individual's spouse, parent, primary caregiver, designated representative, legal guardian, or the spouse of the legal guardian, managing conservator, or persons related to the individual within the fourth degree of consanguinity or within the second degree of affinity.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCS provider agency

HHSC

Frequency of Verification:

The provider agency verifies service provider qualifications prior to completing a service agreement and prior to execution of license or certification.

HHSC verifies provider agency qualification during initial certification and recertification surveys.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Dental Treatment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11070 dental services
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

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

Service Definition *(Scope):*

Elements of this service include the following:
(A) Emergency dental treatment. Those procedures necessary to control bleeding, relieve pain, and eliminate acute infection; operative procedures that are required to prevent the imminent loss of teeth; and treatment of injuries to the teeth or supporting structures.

(B) Preventive dental treatment. Examinations, oral prophylaxes, and topical fluoride applications.

(C) Therapeutic dental treatment. Treatment that includes, but is not limited to, pulp therapy for permanent and primary teeth; restoration of carious permanent and primary teeth; maintenance of space; and limited provision of removable prostheses when masticatory function is impaired, when an existing prosthesis is unserviceable, or when aesthetic considerations interfere with employment or social development. For example, an individual who has a severe dental deformity may receive aesthetic treatment to enhance their opportunities for community integration.

(D) Orthodontic dental treatment. Procedures that include treatment of retained deciduous teeth; cross-bite therapy; facial accidents involving severe traumatic deviations; cleft palates with gross malocclusion that will benefit from early treatment; and severe, handicapping malocclusions affecting permanent dentition with a minimum score of 26 as measured on the Handicapping Labio-lingual Deviation Index.

Cosmetic orthodontia is excluded from the dental treatment service.

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

Dental treatment is provided under this waiver when no other financial resource for such treatment is available or when other available resources have been exhausted. Individuals who are under 21 years of age must first access benefits through the Texas Health Steps--Comprehensive Care Program (EPSDT) before dental treatment may be provided under this waiver. All medically necessary dental treatment for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

The total amount allowable for the dental treatment service is limited to a maximum expenditure of $2,000 per individual per service plan year.

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

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

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

- ☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dental Treatment

Provider Category:

Agency

Provider Type:

Agencies holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify):*

The person providing dental treatment must be licensed as a dentist or dental hygienist under Texas Occupations Code Chapter 256.

Certificate *(specify):*

Certified by HHSC as a provider agency

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

HCS provider agency

HHSC

Frequency of Verification:

The provider agency verifies service provider qualifications prior to completing service agreement and prior to expiration of license.

HHSC verifies provider agency qualifications during initial certification and recertification surveys

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Dietary Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11040 nutrition consultation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Dietary services include:
• Screening and assessment;
• Development of therapeutic treatment plans;
• Direct therapeutic intervention;
• Assistance and training with adaptive aids relative to eating;
• Consulting with other service providers and family members; and
• Participating on the service planning team, when appropriate.

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

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

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

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietary Services

Provider Category:

Agency

Provider Type:

Agencies holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify):*

The dietician must be licensed under Title 3 of the Texas Occupations Code, Subtitle M, Chapter 701.

Certificate *(specify):*

Certified by HHSC as a provider agency

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency

HHSC

Frequency of Verification:

The provider agency verifies service provider qualifications prior to completing service agreement and prior to expiration of license.

HHSC verifies provider agency qualifications during initial certification and recertification surveys.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

specified in statute.

Service Title:

Employment Assistance

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
03 Supported Employment	03010 job development
Category 2:	**Sub-Category 2:**
03 Supported Employment	03030 career planning
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Employment assistance is assistance provided to an individual to help the individual locate paid employment in the community. Employment assistance includes:
- identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions;
- locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements; and
- contacting a prospective employer on behalf of an individual and negotiating the individual's employment.

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 individualized skills and socialization, supported home living, or respite 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 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	Agencies holding a HCS Medicaid provider agreement
Individual	Consumer directed services direct service provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Assistance

Provider Category:

Agency

Provider Type:

Agencies holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by HHSC as a provider agency

Other Standard *(specify):*

The employment assistance service provider must be at least 18 years of age and meet one of the following qualifications:
Option 1:
- have a bachelor's degree in rehabilitation, business, marketing, or a related human services field and at least six months paid or unpaid experience providing employment services to people with disabilities;

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

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

The service provider may not be the individual's legally responsible person or legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCS provider agency
HHSC

Frequency of Verification:

The provider agency verifies service provider qualifications prior to hiring.

HHSC verifies provider agency qualifications during initial certifications and recertification surveys.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Assistance

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The employment assistance service provider must be at least 18 years of age and meet one of the following qualifications:
Option 1:
- have a bachelor's degree in rehabilitation, business, marketing, or a related human services field and at least six months paid or unpaid experience providing employment services to people with disabilities;

Option2:
- have an associate's degree in rehabilitation, business, marketing, or a related human services field and at least one year paid or unpaid experience providing employment services to people with disabilities; or

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

The service provider may not be the individual's legally responsible person or legal guardian.

An individual employer and financial management services agency are both required by 40 Texas Administrative Code Chapter 41 Consumer Directed Services Option to verify that a service provider meets the qualifications required by the individual's program rules before being hired. A financial management services agency is required to obtain and retain documentation on file that a service provider continues to meet the qualifications required by the individual's program rules, policies, and manuals, and other state and federal regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer
Financial management services agency
HHSC

Frequency of Verification:

The individual/employer and financial management services agency verify service provider qualifications prior to hiring.

HHSC verifies provider qualifications were met prior to service delivery during reviews, completed every three years at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Minor Home Modifications

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

This service provides physical adaptations to an individual's home to address specific needs identified by an individual's service plan. Minor home modifications are necessary to ensure the health, welfare, and safety of the individual, or to enable the individual to function with greater independence in his or her home. Modifications may include the installation of permanent ramps and grab-bars, widening of doorways, and other specialized accessibility adaptations, modification of kitchen and bathroom facilities, or safety adaptations necessary for the welfare of the individual.

Minor home modifications must be provided in accordance with applicable state or local building codes and must be a necessary minor home modification listed in Appendix X of the HCS Billing Guidelines and are limited to the following categories, including the repair and/or maintenance of modifications:
(A) Construction or repair of wheelchair ramps and/or landings to A.D.A. specifications
(B) Modifications to bathroom facilities
(C) Modifications to kitchen facilities
(D) Specialized accessibility and safety adaptations

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

The local intellectual and developmental disability authority service coordinator aids in the identification of the need for minor home modifications; however, it is the responsibility of the provider agency to perform all related contacts with non-HCS suppliers of minor home modifications to procure items in accordance with an individual's identified needs.

Pre-enrollment minor home modifications must be pre-authorized and provided prior to the HCS enrollment effective date.

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

Only minor home modifications listed in Appendix X of the HCS Billing Guidelines are billable through the HCS waiver.

The maximum lifetime expenditure for this service is $7,500, which includes pre-enrollment minor home modifications and minor home modifications after enrollment. Providers can bill repairs of minor home modifications under maintenance and repair costs which will not count towards the $7,500 lifetime limit. These repairs will have a limit of $300 per service plan year per individual. Once the maximum limit is reached, only $300 per service plan year per individual will be allowed for repair, replacement, or additional modifications

If an applicant or individual has an identified need for minor home modifications that exceed the lifetime maximum benefit, the local intellectual and developmental disability authority will work with the provider agency and the individual to identify non-waiver resources to assist the individual to address the identified need.

The individual and provider agency must agree on the necessity of all minor home modifications. A minor home modification must be necessary to ensure the health, welfare, and safety of the applicant, or to enable the applicant or individual to function with greater independence. Any modification or combination of modifications costing more than $1000.00 must be agreed upon as necessary by the individual and provider agency based on prior written evaluations and recommendations from the individual's physician, a licensed occupational or physical therapist, a service provider of behavioral supports qualified to assess the individuals need for the specific minor home modification. The written evaluation must document the necessity and appropriateness of the minor home modification to meet the specific needs of the individual. Any modification or combination of modifications costing less than $1,000 only require a recommendation as to their necessity and appropriateness.

Physical therapy and occupational therapy assessments are provided under this waiver service when no other financial resources for such therapies is available, including the Medicaid State Plan. One-time physical therapy and occupational therapy assessments conducted to determine need for minor home modifications as part of transition assistance services will be distinct and billed separately from the extended state plan physical therapy and occupational therapy services included in 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	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Minor Home Modifications

Provider Category:

Agency

Provider Type:

Agencies holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by HHSC as an HCS provider agency

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

HCS provider agency

HHSC

Frequency of Verification:

The provider agency verifies service provider qualifications prior to completing service agreement and prior to expiration of license.

HHSC verifies provider agency qualifications during initial certification and recertification surveys.

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:

Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11030 medication assessment and/or management

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

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

Service Definition *(Scope):*

Nursing provides treatment and monitoring of medical conditions prescribed by a physician/medical practitioner and/or required by standards of professional practice or state law to be performed by licensed nursing personnel.

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

Nursing is provided under this waiver when no other financial resource for such service is available or when other available resources have been used. Individuals who are under 21 years of age must access benefits through the EPSDT before nursing may be provided under this waiver. All medically necessary Nursing Services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit, except for nursing tasks that are required for the provision of a waiver service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer directed services direct service provider
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing

Provider Category:
Individual
Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

The nurse must be licensed as a Registered Nurse or Licensed Vocational Nurse under Title 3 of the Texas Occupations Code, Subtitle E, Chapter 301.

Certificate *(specify):*

Other Standard *(specify):*

An individual employer and financial management services agency are both required by 40 Texas Administrative Code Chapter 41 Consumer Directed Services Option to verify that a service provider meets the qualifications required by the individual's program rules before being hired. A financial management services agency is required to obtain and retain documentation on file that a service provider continues to meet the qualifications required by the individual's program rules, policies, and manuals, and other state and federal regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer
Financial management services agency
HHSC

Frequency of Verification:

Individual/employer and financial management services agency will ensure staff or contractor is appropriately licensed prior to hiring or contracting with service provider and on an ongoing basis.

HHSC during on-site and desk reviews conducted a minimum of every three years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing

Provider Category:

Agency

Provider Type:

Agencies holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify):*

The nurse must be licensed as a Registered Nurse or Licensed Vocational Nurse under Title 3 of the Texas Occupations Code, Subtitle E, Chapter 301.

Certificate *(specify):*

Certified by HHSC as an HCS provider agency

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency

HHSC

Frequency of Verification:

The provider agency verifies service provider qualifications prior to completing the service agreement and prior to expiration of license.

HHSC verifies provider agency qualifications during initial certification and recertification surveys.

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:

Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02021 shared living, residential habilitation
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Residential assistance is provided as one of three residential services in the service array as follows:

Host home/companion care provides individuals with personal assistance with activities of daily living (grooming, eating, bathing, dressing and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of behavioral support or specialized therapies activities; assistance with medications based upon the results of an Registered Nurse assessment the performance of tasks delegated by a Registered Nurse in accordance with the Texas Board of Nursing rules as defined by Title 22 of the Texas Administrative Code, Part 11, Chapter 225; and supervision of the individual's safety and security. This service includes habilitation activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills. Individuals receiving either Adult Foster Care or Texas Department of Family and Protective Services foster care services may not receive host home/companion care through this waiver. Host home/companion care is provided in a private residence meeting HCS requirements by a host home or companion care service provider who lives in the residence. Host home/companion care is combined because the actual services provided are identical. The only distinction is which individual has the property interest in the home in which the services are being provided. In a host home arrangement, the host home service provider owns or leases the residence. In a companion care arrangement, the residence may be owned or leased by the companion care service provider or may be owned or leased by the individual.

Supervised living provides individuals with personal assistance with activities of daily living (grooming, eating, bathing, dressing and personal hygiene)and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of behavioral support or specialized therapies activities; assistance with medications based upon the results of an Registered Nurse assessment, the performance of tasks delegated by a Registered Nurse in accordance with the Texas Board of Nursing rules as defined by Title 22 of the Texas Administrative Code, Part 11, Chapter 225; and supervision of the individual's safety and security. This service includes habilitation activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills. Supervised living provides residential assistance as needed by individuals who live in residences in which the provider agency holds a property interest and that meet program certification standards. This service is provided to individuals by direct service providers who are not awake during normal sleep hours. Supervised living service providers provide services and supports as needed by individuals and are present in the residence and able to respond to the needs of individuals during normal sleeping hours.

Residential support service provides individuals with personal assistance with activities of daily living (grooming, eating, bathing, dressing and personal hygiene)and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of behavioral support or specialized therapies activities; assistance with medications based upon the results of a Registered Nurse assessment, the performance of tasks delegated by a Registered Nurse in accordance with the Texas Board of Nursing rules as defined by Title 22 of the Texas Administrative Code, Part 11, Chapter 225. Transportation costs are included in the rate for all types of residential services. Type and frequency of supervision is determined on an individual basis based on the level of need for each individual.

The provider agency must implement and maintain a plan for initial and periodic training of staff members and service providers that ensures staff members and service providers are qualified to deliver services as required by the current needs and characteristics of the individuals to whom they deliver services and are knowledgeable of acts that constitute abuse, neglect, or exploitation of an individual and methods to prevent the occurrence of abuse, neglect, and exploitation.

Periodic training is determined by the provider agency, as needed, to ensure service providers are qualified to provide HCS services in accordance with state and federal laws and regulations); and supervision of the individual's safety and security. This service includes habilitation activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills. Residential support provides residential assistance to individuals who require supervision and support from direct service providers who are awake and present in the residence whenever an individual is present in the residence. Residential support is provided in residences in which the provider agency holds a property interest and

that meet certification standards. Services and supports are provided by residential support service providers assigned on a shift schedule that includes at least one complete change of staff each day.

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

Payments for residential assistance services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. An individual may receive only one type of residential assistance at a time. Supervised living can serve up to 3 people; residential support services can serve up to 4 people; and host home/companion care can serve up to 3 people.

Residential assistance services cannot be provided at the same time as individualized skills and socialization services.

Individuals who receive residential assistance under this waiver are not eligible to receive either supported home living, state plan community first choice personal assistance services/habilitation, or respite, as these services are available only to individuals who live in their own or family home.

Individuals receiving either Adult Foster Care or Department of Family and Protective Services foster care services may not receive residential assistance through this waiver. Waiver funds cannot be used to pay for residential assistance for children under state conservatorship receiving state foster care and does not supplant the state's responsibilities under Titles IV-E and B.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services)

Provider Category:

Agency

Provider Type:

Agencies holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by HHSC as an HCS provider agency

Other Standard *(specify):*

The service provider of the residential assistance service must be at least 18 years of age. The service provider must have a high school diploma or Certificate of High School Equivalency (General Equivalency Diploma credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served as demonstrated through a written competency-based assessment; and at least three personal references from persons not related by blood that evidence the ability to provide a safe and healthy environment for the individual(s) to be served.

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

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

The service provider of residential assistance must complete initial and periodic training provided by the provider agency in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D, §9.177.

The provider agency must implement and maintain a plan for initial and periodic training of service providers. Periodic training is determined by the provider agency, as needed, to make sure service providers are qualified to provide HCS services in accordance with state and federal laws and the current needs and characteristics of the individuals to whom they deliver services. The provider agency must also ensure that service providers are knowledgeable of acts that constitute abuse, neglect, and exploitation; methods to prevent the occurrence of abuse, neglect, and exploitation; and proper reporting of possible instances of abuse, neglect, and exploitation.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCS provider agency

HHSC

Frequency of Verification:

The provider agency verifies service provider qualifications prior to completing service agreement and prior to expiration of license.

HHSC verifies provider agency qualifications during initial certification and recertification surveys.

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:

Social Work

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11130 other therapies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Social work services include:

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Social Work

Provider Category:

Agency

Provider Type:

Agencies holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify):*

Licensed Social Worker under Title 3 of the Texas Occupations Code, Subtitle I, Chapter 505.

Certificate *(specify):*

Other Standard *(specify):*

Guardians and persons related to the individual within the fourth degree of consanguinity or within the second degree of affinity may not provide social work services for the individual.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCS provider agency

HHSC

Frequency of Verification:

The provider agency verifies service provider qualifications prior to completing service agreement and prior to expiration of license.

HHSC verifies provider agency qualifications during initial certification and recertification surveys.

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:

Supported Home Living

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Supported home living provides individuals with direct personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene)and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of behavioral support or specialized therapies activities; assistance with medications and the performance of tasks delegated by a registered nurse in accordance with the Texas Board of Nursing rules as defined by Title 22 of the Texas Administrative Code, Part 11, Chapter 225; and supervision as needed to ensure the individual's health and safety; and supervision of the individual's safety and security. This service includes habilitation activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills.

Supported home living is provided to individuals residing in their own residence or the residence of their natural or adoptive families or to individuals receiving foster care from the Texas Department of Family and Protective Services. Supported home living provided to individuals residing with their family members is designed to support rather than supplant the family and natural supports. Individuals residing in their own homes receive supported home living as necessary to support them in their independent residence.

Individuals under the conservatorship of the State may receive foster care services paid for through state funds. Foster care provided by the State to individuals under state conservatorship provides services specifically to maintain these individuals and includes supports such as those provided to children by their natural parents. This service does not include the specialized supports offered through supported home living. When an individual under state conservatorship receiving state foster care enrolls in HCS, he or she is eligible to receive supported home living in the state foster care setting, the same as children living in their family home are eligible to receive this service. For individuals who are under state conservatorship, are receiving state foster care, and are diagnostically eligible for the HCS waiver, supported home living is intended to offer needed specialized "wrap-around" supports to the individual in his or her residential setting. The provision of this service does not duplicate maintenance support provided to the individual through state foster care.

Transportation provided to individuals in accordance with guidelines is a billable supported home living service. Transportation costs which are not billable, but which are incurred to provide the supported home living service, are included in the indirect portion of the rate.

Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D specifies that service providers must be knowledgeable about the individual needs of each individual served and be knowledgeable about what constitutes abuse, neglect, and exploitation and how to report abuse, neglect, and exploitation. Frequency of periodic training is not prescribed, but provider agencies must ensure that service providers can demonstrate this knowledge during HHSC Long-Term Care Regulation reviews.

Title 22 of the Texas Administrative Code, Part 11, Chapter 225, §225.10 specifies the Board of Nursing requirements for delegation and specifies the tasks which may be delegated and tasks which do not require delegation. Registered Nurses must adhere to the Board of Nursing requirements regarding delegation.

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

Supported home living cannot be provided at the same time as individualized skills and socialization or respite.

Individuals receiving supported home living services are not eligible to simultaneously receive residential assistance services.

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

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

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer directed services direct service provider
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Home Living

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The supported home living service provider must be at least 18 years of age. The service provider must be an employee of the individual/employer and must have a high school diploma or Certificate of High School Equivalency (General Equivalency Diploma credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served as demonstrated through a written competency-based assessment; and at least three personal references from persons not related by blood that demonstrates the ability to provide a safe and healthy environment for the individual(s) to be served.

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

Assisting with tasks delegated by a Registered Nurse must be in accordance with state law. Title 22 of the Texas Administrative Code, Part 11, Chapter 225, §225.10 specifies the Board of Nursing requirements for delegation and specifies the tasks which may be delegated and tasks which do not require delegation. Registered Nurses must adhere to the Board of Nursing requirements regarding delegation.
The service provider of supported home living must not live with the individual. The individual's guardian, designated representative or spouse of the designated representative may not be the service provider of supported home living services for the individual.

The service provider of supported home living must complete initial and periodic training provided by the individual employer in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D, §9.177.

The individual employer must implement a plan for initial and periodic training of direct service providers. Periodic training is determined by the individual/employer, as needed, to make sure service providers are qualified to provide HCS services in accordance with state and federal law service providers that ensures direct service providers are qualified to deliver services as required by state and federal laws and must ensure that direct service providers are knowledgeable of acts that constitute abuse, neglect, or exploitation of individual; methods to prevent the occurrence of abuse, neglect, and exploitation; and proper reporting of possible instances of abuse, neglect, and exploitation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer

Financial management services agency

HHSC

Frequency of Verification:

Individual/employer and financial management services agency will ensure staff or contractor is appropriately licensed prior to hiring or contracting with the service provider and on an ongoing basis.

HHSC during on-site and desk reviews conducted a minimum of every three years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Home Living

Provider Category:

Agency

Provider Type:

Agencies holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by HHSC as an HCS provider agency

Other Standard *(specify):*

The supported home living service provider must be at least 18 years of age. The service provider must have a high school diploma or Certificate of High School Equivalency (General Equivalency Diploma credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served as demonstrated through a written competency-based assessment, and at least three personal references from persons not related by blood that evidence the ability to provide a safe and healthy environment for the individual(s) to be served.

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

Assisting with tasks delegated by a Registered Nurse must be in accordance with state law. Title 22 of the Texas Administrative Code, Part 11, Chapter 225, §225.10 specifies the Board of Nursing requirements for delegation and specifies the tasks which may be delegated and tasks which do not require delegation. Registered Nurses must adhere to the Board of Nursing requirements regarding delegation.
The service provider of supported home living must not live with the individual.

The service provider of supported home living must complete initial and periodic training provided by the provider agency in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D, §9.177.

The provider agency must implement and maintain a plan for initial and periodic training of service providers. Periodic training is determined by the program provider, as needed, to make sure service providers are qualified to provide HCS services in accordance with state and federal laws and the current needs and characteristics of the individuals to whom they deliver services. The program provider must also ensure that service providers are knowledgeable of acts which constitute abuse, neglect, and exploitation; methods to prevent the occurrence of abuse, neglect, and exploitation; and the proper reporting of possible instances of abuse, neglect, and exploitation.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCS provider agency

HHSC

Frequency of Verification:

The provider agency verifies service provider qualifications prior to completing service agreement and prior to expiration of license.

HHSC verifies provider agency qualifications during initial certification and recertification surveys.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transition Assistance Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Transition assistance services pay for non-recurring set-up expenses for applicants transitioning from an intermediate care facility for individuals with an intellectual disability or related condition, a nursing facility, or a General Residential Operation into the HCS waiver. Transition assistance services are billed on or after the individual's enrollment date into the waiver.

Allowable expenses are those necessary to enable applicants to establish basic households and may include: security deposits for leases on apartments or homes; essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture; window coverings; food preparation items; and bed and bath linens; set-up fees or deposits for utility or service access, including telephone, electricity, gas, and water; services necessary for the applicant's health and welfare, such as pest eradication and one-time cleaning of the residence prior to occupancy; and activities to assess need for, facilitate, arrange for, and procure needed resources, (limited to up to 180 consecutive days prior to discharge from the intermediate care facility for individuals with an intellectual disability or related condition, general residential operation, or nursing facility and entrance to the waiver).

Room and board are not allowable expenses.

Transition assistance services do not include: monthly rental or mortgage expenses; food; regular utility charges; or household appliances or items that are intended for purely diversional or recreational purposes.

Transition assistance services funding is authorized for expenses that are reasonable and necessary as determined through the service plan development process; and that are clearly identified in the individual service plan, and for which applicants are unable to pay for or obtain from other sources.

To be eligible to receive transition assistance services the applicant must be a resident of a Texas nursing facility, intermediate care facility for individuals with an intellectual disability or related condition, or General Residential Operation who wishes to be discharged from that facility; be a Medicaid recipient; and be determined eligible for the HCS waiver. Transition assistance services must be pre-authorized and provided prior to the HCS enrollment effective date.

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

Transition assistance services are one-time initial expenses for setting up an individual's household.

Transition assistance services are limited to up to 180 consecutive days prior to discharge from the intermediate care facility for individuals with an intellectual disability or related condition, General Residential Operation, or nursing facility and entrance to the waiver.

For applicants transitioning into a service provider leased/owned living arrangement or a host home/companion care setting, the amount for TAS cannot exceed $1,000. This can only be used for personal bedroom furniture, linens and allergen control.

The amount for allowable expenses necessary to enable applicant to establish basic households - cannot exceed $2,500 for applicants transitioning into their own home/family home. This can only be used for:

-Security deposits for leases on apartments or homes;
-Essential household furnishings to establish basic living arrangement and moving expenses in a community domicile, including furniture, window coverings, and food preparation items;
-Set-up fees or deposits for utility or service access, including telephone, electricity, gas, and water;
-Services necessary for the applicants health and welfare such as pest eradication, allergen control, and one-time cleaning prior to occupancy; and
-Activities to assess need, arrange for, and procure needed resources (limited to up to 180 consecutive days prior to discharge from the institution).

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Assistance Services

Provider Category:

Agency

Provider Type:

Agencies holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by HHSC as an HCS provider agency or Certified by HHSC as a TAS service provider

Other Standard *(specify):*

The service provider of transition assistance services must be at least 18 years of age. The service provider must have a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma. The service provider must not be a relative or legally authorized representative of the applicant and may not live with the applicant. The service provider must be capable of providing transition assistance services and complying with the documentation requirements described in Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D, §9.174(g)(2)(A) relating to Certification Principles: Service Delivery.

Verification of Provider Qualifications

Entity Responsible for Verification:

HHSC

Frequency of Verification:

The provider agency verifies service provider qualifications prior to completing service agreement and prior to expiration of license.

HHSC verifies provider agency qualifications during initial certification and recertification surveys.

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:

HHSC holds performance contracts with local community centers, established in accordance with Texas Health and Safety Code, Chapter 534, and with a local Council of Government, established in accordance with Texas Local Government Code, Chapter 391. These entities have been designated by HHSC as local intellectual and developmental disability authorities in accordance with Texas Health and Safety Code, §533.035, and serve specific geographic areas. In accordance with the state legislative mandate to transfer case management functions in HCS to the local intellectual and developmental disability authorities, effective June 1, 2010, these entities provide service coordination (case management) to individuals who receive HCS waiver services.

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):

Provider agencies, local intellectual and developmental disability authorities, and individual employers must conduct a statewide criminal history check in compliance with the Texas Health and Safety Code, Chapter 250 including taking the following actions regarding applicants, employees, and contractors:
(A) Obtain criminal history record information from the Texas Department of Public Safety that relates to an unlicensed applicant, employee, or contractor whose duties involve direct contact with an individual receiving waiver services; and
(B) Refrain from employing or contracting with, or immediately discharge, a person who has been convicted of an offense that bars employment under Texas Health and Safety Code, Chapter 250, Sec. 250.006(a), or an offense that the program provider or individual employer determines is a contraindication to the person's employment or contract to provide services to the individual.

Individuals choosing to self-direct services must choose a financial management services agency that provides guidance and assistance to the individual with employer-related tasks.

Financial management services agencies must complete a criminal history check before a person may become an employee, volunteer, or a contractor, in compliance with Title 40 of the Texas Administrative Code, Part 1, Chapter 41, and Title 40 of the Texas Administrative Code, Part 1, Chapter 49. Financial management services agencies and individual/employers or their designated representative must comply with rules in Title 40 of the Texas Administrative Code, Part 1, Chapter 41. These rules require a criminal history check before a person may become an employee or a contractor of the individual/employer in compliance with Title 40 of the Texas Administrative Code, Part 1, Chapter 41. If contracting with a service provider, the employer or designated representative must complete an agreement with the entity certifying that the entity has checked and verified that each person delivering a service to the individual on behalf of the entity has not been convicted of an offense listed in Title 4 of the Texas Health and Safety Code, Chapter 250, §250.006(b) within the previous five years. The financial management services agency is required to have verification of criminal history checks prior to the contractor or employees first day of work.

Provider agencies, financial management services agencies, and local intellectual and developmental disability authorities are required to maintain documentation of the criminal history checks performed.

Financial management services agencies, provider agencies and local intellectual and developmental disability authorities must screen all employees and contractors for exclusion prior to hiring or contracting, and on an ongoing monthly basis, by searching both the HHSC and federal Office of Inspector General lists of excluded individuals and entities. All program providers must develop and implement written policies and procedures that require the provider to review the list of excluded individuals and entities at the Texas HHSC Office of Inspector General website and the federal HHSC Office of Inspector General website before hiring or contracting with a person or entity and at least once a month while the provider employs or contracts with the person or entity. If any exclusion is discovered the provider must immediately report the findings to HHSC.

Financial management services agencies are required to document and maintain the time and the result of the registry check on the HHSC Criminal Conviction History and Registry Checks form which is reviewed by HHSC during a monitoring review and may be reviewed during a complaint investigation.

During the on-site reviews, HHSC verifies that the financial management services agencies, provider agencies and local intellectual and developmental disability authorities have conducted screening for exclusion and performed other applicable registry checks.

HHSC relies on regulatory boards to perform background checks as part of the licensing process.

As part of on-site reviews of providers and financial management services agencies, HHSC monitors if criminal history checks are conducted as required.

Provider agencies, employers, and financial management services agencies must comply with the Texas Health and Safety Code, Chapters 250 and 253, including taking the following action regarding applicants, contractors, and employees:
- annually search the Nurse Aide Registry maintained by HHSC in accordance with Texas Health and Safety Code, Chapter 250, and refrain from employing or contracting with, or immediately discharge, a person who is

designated in the registry as having abused, neglected, or mistreated an individual receiving services or has misappropriated an individual's property; and

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

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):

All paid or unpaid service providers who are not licensed are required to undergo Abuse Registry screenings by provider agencies. The appropriate licensure boards are responsible for monitoring licensed professionals.

Provider agencies and individual employers must comply with the Texas Health and Safety Code, Chapters 250 and 253, by taking the following actions regarding applicants, employees, and contractors:
(A) Search the Nurse Aide Registry maintained by HHSC in accordance with Texas Health and Safety Code, Chapter 250, and refrain from employing or contracting with, or immediately discharge, a person who is designated in the registry as having abused, neglected, or mistreated an individual of a facility or has misappropriated an individual's property; and
(B) Search the Employee Misconduct Registry maintained by HHSC in accordance with Texas Health and Safety Code, Chapter 253, and refrain from employing or contracting with or immediately discharge a person whose employment involves direct contact with an individual, and who is designated in the registry as having abused, neglected, or exploited an individual or has misappropriated an individual's property.

Provider agencies, financial management services agencies, and local intellectual and developmental disability authorities are required to maintain documentation of the Nurse Aide Registry and Employee Misconduct Registry checks performed. During at least annual on-site reviews of provider agencies and local intellectual and developmental disability authorities, HHSC monitors for completion of required registry checks. Contract monitoring for financial management services agencies is conducted at a minimum every three years.

Appendix C: Participant Services

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

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

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 who are not legally responsible for the individual, and who meet qualifications, may provide HCS services with the following exceptions:
-Supported home living and respite may not be provided by persons, including guardians and relatives, who live with the individual.
-Guardians and persons related to the individual within the fourth degree of consanguinity (blood relation) or within the second degree of affinity (by marriage) may not provide service coordination, residential support services, supervised living, behavioral support services, social work services, or adaptive aids for the individual.
-The spouse of an individual may not provide any waiver service to the individual.
-The parent of a minor child may not provide any waiver service to the individual.
-The Consumer Directed Services employer or employer spouse may not provide any waiver service to the individual.
- The designated representative or designated representative's spouse may not provide any waiver service to the individual.

Documentation requirements are the same for relatives and guardians who are service providers as for all other service providers. If the individual has a relative licensed by the State of Texas in that field, the State does not prohibit that relative from providing the service to the individual. Provider agencies must ensure completion of required documentation and financial management services agencies require submission of required documentation before paying the service provider and submitting a billing claim.

HHSC monitors compliance with policies concerning eligibility of service providers and completion of required documentation through provider agency survey and certification reviews, provider fiscal compliance reviews of provider agencies, and contract monitoring of financial management services agencies.

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

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

○ **Other policy.**

Specify:

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

The following processes are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in Title 42 of the Code of Federal Regulations, Section §431.51:

In order to obtain a Medicaid provider agreement as a provider agency, a provider applicant must apply in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 49. New provider agency applications are accepted by HHSC on an ongoing basis. As part of the provider agency enrollment process, new provider agencies are required to complete new provider agency training and receive a score of at least 85 percent on a provider competency exam.

Qualified provider agencies agree to provide all HCS waiver services. This model of service delivery has been approved by CMS since 1985 and is in use in other currently CMS-approved Texas home and community-based services waivers. This model of service delivery accomplishes the following for individuals receiving HCS waiver services:
- ensures the availability of each service across the state, even in rural areas where, without the use of the current definition of qualified provider agency, not all waiver services would be readily accessible;
- recognizes that a vast majority of individuals 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 individuals' service needs as provider agencies are required to make all services available when and as they are needed;
- establishes a single point of accountability for provision of needed services; and
- decreases administrative costs.

In addition to promoting efficient service delivery, the HCS waiver service delivery model does not compromise an individual's choice of qualified provider agencies or waiver service providers. In all 254 counties, no matter how sparsely populated, individuals have a choice between at least two provider agencies. In most cases, individuals have a choice among numerous provider agencies. With regard to an individual's choice of service providers, HCS rules at Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D, §9.173 require the provider agency to protect and promote the individual's right to choose among various available service providers.

Information about obtaining a HCS Medicaid provider agreement is provided by contacting the HHSC Contract Administration and Provider Monitoring unit.

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 newly enrolled contracted providers that initially met contract requirements before providing services. N: Number of newly enrolled contracted providers that initially met contract requirements before providing services. D: Number of newly enrolled contracted providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
System of Contract Operation and Reporting

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

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

Data Aggregation and Analysis:

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

Performance Measure:
C.a.2 Number and percent of active, surveyed contracts for which the provider met contract requirements following enrollment and continually thereafter. N: Number of active, surveyed contracts for which the provider met contract requirements following enrollment and continually thereafter, as evidenced by the avoidance of decertification or vendor hold. D: Number of active, surveyed contracts.

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

Responsible Party for	**Frequency of data**	**Sampling Approach**

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

Data Aggregation and Analysis:

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

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

Performance Measure:
C.a.3 Number and percent of contracts surveyed to ensure that providers are initially and continually meeting all certification principles. N: Number of contracts surveyed to ensure that providers are initially and continually meeting all certification principles. D: All contracts that received an initial or recertification survey.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
C.a.4 Number and percent of contracts released from vendor hold. N: Number of contracts released from vendor hold. D: Number of contracts placed on vendor hold.

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Performance Measure:
C.b.1 Number and percent of newly enrolled financial management services agency contracts that met initial qualifications. N: Number of newly enrolled financial management services agency contracts that met initial qualifications. D: Number of newly enrolled financial management services agency contracts.

Data Source (Select one):
Other
If 'Other' is selected, specify:
System of Contract Operation and Reporting

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

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

Data Aggregation and Analysis:

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

Performance Measure:
C.b.2 Number and percent of monitored FMSA contracts that continually met contract monitoring requirements, evidenced by an overall compliance score of at least 90%. N: Number of monitored FMSA contracts that continually met contract monitoring requirements, evidenced by an overall compliance score of at least 90%. D: Number of FMSA contracts monitored using the CDS-Program Tool.

Data Source (Select one):
Other
If 'Other' is selected, specify:
System of Contract Operation and Reporting

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: FMSAs are selected for monitoring based on contract effective date, previous formal monitoring exit date, overall compliance score of the previous formal monitoring, and expenditures.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
C.b.3 Number and percent of monitored FMSA contracts that continually met fiscal monitoring requirements, evidenced by an overall compliance score of at least 90%. N: Number of monitored FMSA contracts that continually met fiscal monitoring requirements, evidenced by an overall compliance score of at least 90%. D: Number of FMSA contracts monitored using the CDS-Tax Tool.

Data Source (Select one):
Other
If 'Other' is selected, specify:
System of Contract Operation and Reporting

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: FMSA legal entities are selected for monitoring based on contract effective date, previous formal monitoring exit date, overall compliance score of the previous formal monitoring, and expenditures.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

Performance Measure:
C.c.1 Number and percent of newly enrolled contracted providers meeting initial provider training requirements according to the approved waiver. N: Number of newly enrolled contracted providers meeting initial provider training requirements according to the approved waiver. D: Number of newly enrolled contracted providers that required initial training.

Data Source (Select one):
Other
If 'Other' is selected, specify:
System of Contract Operation and Reporting

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

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

Data Aggregation and Analysis:

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

Performance Measure:
C.c.2 Number and percent of newly enrolled FMSAs that attended all initial required training in accordance with the approved waiver. N: Number of newly enrolled FMSAs that attended all initial required training in accordance with the approved waiver. D: Number of newly enrolled FMSAs requiring initial training.

Data Source (Select one):
Other
If 'Other' is selected, specify:
System of Contract Operation and Reporting

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

Data Aggregation and Analysis:

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

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

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 monitors program providers for compliance with HCS certification principles, billing and payment guidelines, policies and procedures; and the terms of the Medicaid provider agreement.

HHSC Long-Term Care Regulation monitors the performance of program providers by completing initial and annual on-site reviews to determine compliance with the HCS certification principles. HHSC Long-Term Care Regulation certifies providers annually. A representative sample of service provider records are reviewed to ensure criminal background checks are performed as required. This data is reported for the quarter in which the program provider is monitored resulting in no overlaps in reporting/monitoring.

HHSC Long-Term Care Regulation also conducts additional reviews when significant issues or complaints are identified. Following certification reviews, all program providers receive a written certification review report that details any specific areas of non-compliance found during the review and includes instruction regarding the program provider’s responsibility with regard to the areas of deficiency. During initial on-site and annual reviews of program providers, HHSC verifies that the program provider has systems in place to verify that minimum staff qualifications are met and a process to conduct required training.

One hundred percent of financial management services agencies are monitored every three years. HHSC monitors a certain number of financial management services agencies each year. This data is reported for the year in which the program provider is monitored resulting in no overlaps in reporting/monitoring.

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

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 HHSC Long-Term Care Regulation determines after an initial or annual survey that the provider agency is in compliance with all certification principles, HHSC certifies the provider agency. If HHSC Long-Term Care Regulation determines based on a survey that the provider agency is not in compliance with all of the certification principles, HHSC takes one or more of the following actions: requires a plan of correction; conducts a follow-up survey; requires evidence of correction; imposes an administrative penalty; imposes a vendor hold; or denies or terminates certification.

A provider agency's plan of correction must specify the date by which corrective action will be completed for each violation. For a critical violation, the date must be no later than 30 calendar days after the date of the review exit conference. For a non-critical violation, the date must be no later than 45 calendar days after the date of the survey exit conference.

If HHSC approves the plan of correction (POC), the provider agency must complete the corrective action in accordance with the plan of correction. If HHSC does not approve the plan of correction, the provider agency must submit a revised plan of correction
Verification of corrective action: HHSC may:
• request that the program provider submit evidence of correction to HHSC; or
• conduct a survey:
o for a critical violation, after the date specified in the POC for correcting the violation but within 45 days after the survey exit conference, or, for a non-critical violation, at least 46 days after the survey exit conference, unless the provider agency requests that HHSC conducts an earlier follow-up survey as allowed in state rules.

HHSC may impose and collect an administrative penalty against an HCS service provider for a violation of a certification principle contained in the Texas Administrative Code pertaining to the HCS program. HHSC may also impose and collect an administrative penalty against an HCS service provider for any of the following actions: making a false statement of a material fact the provider agency knows or should know is false with respect to a matter under investigation by HHSC; falsifying documentation; willfully interfering with the work of a representative of HHSC; or failing to pay an administrative penalty within 10 calendar days after the date the assessment of the penalty becomes final.

If HHSC Long-Term Care Regulation implements a vendor hold against the provider agency, HHSC Long-Term Care Regulation conducts a second on-site follow-up review between 30 and 45 calendar days after the effective date of the vendor hold. Based on the results of the review, HHSC Long-Term Care Regulation may certify the provider agency and remove the vendor hold or may deny certification of the provider agency and initiate termination of the provider agency agreement.

HHSC Contracts Administration and Provider Monitoring reviews FMSA service providers, providing them with technical assistance at the exit conference of reviews. If, during a contract monitoring review, a financial management services agency is discovered to not have met Medicaid provider agreement requirements the agency is required to submit a corrective action plan to HHSC. The corrective action plan must contain the following elements:

- A description of the non-compliance identified by HHSC;
- A description of the activities that will be performed to correct or prevent the non-compliance from reoccurring;
- the title of the person responsible for performing the activities; and
- a schedule for performing the activities.

If a corrective action plan is requested from the financial management services agency, the agency is informed that they may contact HHSC staff with any questions or requests for clarification of what constitutes an acceptable corrective action plan. Upon submittal, HHSC reviews the corrective action plan and either approves or, if the submitted plan does not include all of the required elements, requests revisions and resubmission of the plan. Financial management services agencies are informed that their failure to ensure HHSC receives an acceptable corrective action plan by the date specified at the exit conference by HHSC may result in HHSC taking adverse action against the agency, up to and including vendor hold or termination of the Medicaid provider agreement. HHSC monitors the corrective action plan until the financial management services agency is in

compliance.

HHSC Contract Monitoring staff submits Medicaid provider agreement/contract action recommendations for financial management services agencies to the Adverse Action Review Committee when a complaint investigation against a financial management services agency substantiates a reported allegation, or staff recommend the agency receive a contract action/sanction greater than a corrective action plan. Adverse Action Review Committee members review the monitoring review results and, if applicable, review complaint investigation findings to ensure the circumstances support the recommended provider agency agreement/contract action. The Adverse Action Review Committee makes a decision on the appropriate action to take, including submission of a corrective action plan; placing a hold on individual referrals for new clients; placing a hold on provider agency payments; financial recoupment; involuntary contract termination; and debarment.

Results of each financial management services agency contract monitoring review are documented and recorded in an Access database maintained in the state office.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

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

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

Minor home modifications delivered through transition assistance services prior to enrollment and minor home modifications delivered after enrollment have a combined maximum lifetime expenditure of $7,500. The maximum allowable amount for these services is based on legislative and leadership direction. Leadership direction and additional funding would be needed to re-evaluate methodology and adjust the service limit to take into account any potential increase in cost. The minor home modification lifetime limit is based on available funding. Exceptions are not made to the minor home modification lifetime service limit, pre-enrollment minor home modifications, or the annual service plan cost ceiling. The Local Intellectual and Developmental Disability Authority (LIDDA) service coordinators are responsible for assisting individuals with locating and securing non-waiver resources to meet their needs prior to utilizing waiver services as well as when service limits in the waiver have been met. If the lifetime limit or the annual service plan limit has been met and the individual is not able to secure other non-waiver resources, the LIDDA service coordinator assists the individual in evaluating other options such as the possible transition to the STAR+PLUS waiver, or institutional services. The service limits for minor home modifications and pre-enrollment minor home modifications are detailed and publicly available in the Texas Administrative Code for the HCS program as well as in the waiver application both available on HHSC's website.

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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

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

Individualized Skills and Socialization Settings

Individualized Skills and Socialization will include an on-site component and off-site component that is community-based. On-site Individualized Skills and Socialization will be delivered in brick-and-mortar buildings owned or controlled by the Individualized Skills and Socialization provider, including settings where Day Habilitation is currently provided. Individualized Skills and Socialization providers will be required to obtain a license and on-site settings must meet requirements of the federal HCBS settings regulations. Off-site Individualized Skills and Socialization will be delivered in the greater community.

Compliance with the federal HCBS Settings Requirements

Through processes implemented as outlined in the state's statewide transition plan, the state requires all settings to be in full compliance with the settings criteria as of March 17, 2023. The state will ensure ongoing compliance of all settings through the following processes: HHSC Long-Term Care Regulatory (LTCR) will conduct on-site licensure surveys of all on-site Individualized Skills and Socialization settings. If the setting where on-site Individualized Skills and Socialization will be provided is in the same building as, on the grounds of, or immediately adjacent to an institutional setting, a prospective Individualized Skills and Socialization provider will be required to undergo heightened scrutiny and be approved by CMS before applying for a license. HHSC LTCR will conduct on-site inspections every two years for licensed Individualized Skills and Socialization providers to ensure ongoing compliance with the federal HCBS settings regulations. Texas Administrative Code rules will require the settings where Individualized Skills and Socialization is delivered to meet the federal HCBS settings requirements. The state will address any areas of non-compliance identified as of March 17, 2023 through a corrective action plan with CMS.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Service Plan

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

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☒ **Other**
Specify the individuals and their qualifications:

To support the philosophy of person-directed planning, service plans in HCS are comprised of three documents:
-the person-directed plan,
-the individual plan of care, and
-the implementation plan.

The service planning team is responsible for developing the person-directed plan. The service planning team consists of the local intellectual and developmental disability authority service coordinator, the individual, and any persons chosen by the individual. The person-directed plan identifies the individual's desired outcomes and identifies the waiver service components the individual needs to meet their desired outcomes. The service planning team and provider agency develops the individual plan of care, which specifies all waiver and non-waiver services supporting the individual. The provider agency develops the implementation plan which describes how waiver services will be delivered and what strategies will be implemented to support the individual in accomplishing his or her outcomes.

Service coordinators must be employees of the local intellectual and developmental disability authorities (LIDDA) in order to provide service coordination to individuals in this waiver and must meet the following criteria:

1. Have a bachelor's or advanced degree from an accredited college or university;

2. Have an associate degree in a social, behavioral, human service, or health-related field including, but not limited to, psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human development, gerontology, educational psychology, education, and criminal justice; or

3. Have a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma, and two years of paid or unpaid experience with individuals with intellectual or developmental disabilities.

4. The LIDDA, at its discretion, may require additional education and experience for staff who provide service coordination.

5. At the discretion of the LIDDA, a staff person who was authorized by a LIDDA to provide service coordination prior to April 1, 1999, may provide service coordination without meeting the minimum qualifications described above;

6. Until December 31, 2011, a LIDDA may hire a person to provide service coordination who was employed as a case manager for an HCS provider agency for any period of time prior to June 1, 2010, even if the person does not meet the minimum qualifications described above.

7. Beginning January 1, 2012, a LIDDA may hire a person to provide service coordination who was hired by another LIDDA in accordance with number six of this section.

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 local intellectual and developmental disability authority (LIDDA) is the only willing and qualified provider to develop the person-directed plan, which is a part of the service plan, based on direction from the legislature. As noted in Appendix C-1 (c), Community Centers and a Council of Government are designated as LIDDAs to provide targeted case management for individuals in HCS. These entities have been designated by HHSC as LIDDAs in accordance with Texas Health and Safety Code, §533A.035, and, as part of their contractual responsibilities, provide targeted case management for HCS waiver program individuals. A community center, in its role as a LIDDA, provides service coordination to individuals in HCS programs consistent with the provisions relating to targeted case management for persons with intellectual and developmental disabilities contained in the approved Texas Medicaid state plan. Under those provisions, employees of LIDDAs are authorized to provide targeted case management.

A LIDDA conducts all enrollment activities for waiver applicants. Applicants and recipients may request a change in service coordinators from the LIDDA, but the service coordinator must be an employee of the LIDDA serving the geographic area where the applicant will receive HCS waiver services. A LIDDA may also hold an HCS Medicaid provider agreement with HHSC. In these situations, the administrative authority and provider services sections are separate and distinct from one another organizationally and in practice.

At enrollment and upon renewal of the individual plan of care, the service coordinator must inform the individual or legally authorized representative (LAR) about available services and supports and the service delivery options. If the individual accepts the offer of HCS waiver services, the individual selects a provider agency that has a Medicaid provider agreement with the State. In the instance in which an individual has chosen the consumer directed services delivery option, the selection of a provider agency is optional so long as no provider services are selected.

After the initial person-directed plan is developed at enrollment, the service planning team, which includes the individual and LAR, service coordinator, and other persons as chosen by the individual or LAR meet at least annually to review the individual's goals, non-waiver and waiver service needs and develop the person-centered plan. The provider agency, individual, and legally authorized representative develop the service plan based on the person-directed plan. The service coordinator is responsible for reviewing the service plan to ensure it is reflective of the services identified in the person-directed plan. If the service coordinator determines the service plan does not reflect the services identified in the person-centered plan and disagrees with the service plan which has been submitted, the service coordinator indicates the disagreement in the HHSC data system. The individual plan of care, including the service coordinator's disagreement, is electronically submitted to HHSC through the HHSC data system. The safeguards are built into the role of the service coordinator and the additional oversight provided by HHSC as the Medicaid agency.

HHSC conducts reviews of LIDDAs to determine if the LIDDA is in compliance with state rules governing the HCS program, the provision of service coordination, and the performance contract. At least annually, HHSC Long-Term Care Regulation conducts initial and recertification surveys of all HCS provider agencies who are providing services to at least one individual, to determine whether the HCS provider agency is in compliance with all of the HCS certification principles.

Further, HHSC reviews the administrative functions of the local intellectual and developmental disability authority annually, including the provision of service coordination. The LIDDA is responsible for service coordination which includes the development of the individual's person-centered service plan. The HCS provider agency would never be responsible for developing this portion of the service plan. If the LIDDA is also chosen by the individual or LAR to be the provider agency, the service coordination functions are kept separate and distinct from the provider functions. LIDDAs are required to provide service coordination per their performance contract with the state. In the event that an individual service coordinator is not able to perform their job duties, a different service coordinator would be assigned by the LIDDA. There would never be a situation in which the HCS waiver services provider agency would be responsible for developing a person-centered plan. A LIDDA may hold a Medicaid provider agreement with the State. In these situations, the administrative and provider services sections are separate and distinct from one another organizationally and in practice. The service coordinator is prohibited from providing direct waiver services to the individual. LIDDAs who have chosen to contract with HHSC to provide HCS services must ensure that the HCS program operation is organizationally separate from the service coordination operations. Service coordinators are prohibited from providing direct services and are not employed by the section of the LIDDA that serves as the HCS service provider. (the remainder of D.1.b is located under the optional section)

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.

During enrollment, the service coordinator ensures that the individual and legally authorized representative, and any other person chosen by the individual, participate in developing a person-directed plan that describes the waiver services and non-waiver services and supports. This is accomplished through person-centered planning. Person-centered planning is a process that empowers individuals and their legally authorized representative, when applicable, to direct the development of a plan of supports and services that meet their personal outcomes by identifying the necessary supports and services, including natural supports. Person-centered planning focuses on individuals directing their service provision, meeting the outcomes that are important to the individuals, including the people and supports chosen by the individuals and accommodating the individuals' style of interaction and preferences regarding time and setting.

The service coordinator also educates the individual and legally authorized representative about service delivery options and services available through the HCS waiver that will contribute to outcome achievement. The service coordinator must inform the individual and legally authorized representative, orally and in writing, of the eligibility criteria for participation in the HCS waiver; the services and supports provided by the HCS waiver, including the limits on those services and supports; and the reasons an individual's HCS waiver services may be terminated.

If the service planning team determines that transition assistance services are needed in order to meet an individual's health and safety needs at the time an individual enrolls, such services may be authorized by the service planning team prior to the individual's enrollment.

Once the enrollment process is complete, the local intellectual and developmental disability authority provides ongoing service coordination to the individual. The individual's service coordinator maintains current contact information for the service coordinator, the provider agency, and the individual, including current contact information for the service coordinator's backup. The service coordinator must ensure that the individual, family, or legally authorized representative, as appropriate, have the contact information.

The service planning team meets to update the individual's person-directed plan when the individual's desired outcomes change. The service planning team consists of the individual and their legally authorized representative, the service coordinator, and any persons chosen by the individual or legally authorized representative.

Revisions to the individual's plan of care occur when the individual's needs change. A request to revise the individual plan of care may be initiated by the individual/legally authorized representative, the provider agency, or service coordinator.

Annually, the person-directed plan and individual plan of care are updated and renewed prior to the expiration of the individual plan of care. The service planning team reviews the current person-directed plan, including the individual's desired outcomes, and updates the information as necessary. The service coordinator also provides an explanation of the individual's rights and responsibilities, which includes the right to transfer to another provider agency or financial management services agency, and the right to change service delivery options.

The provider agency, if applicable, the service coordinator, the individual, legally authorized representative, and any persons chosen by the individual or legally authorized representative renew the individual plan of care based on the updated person-directed plan.

In the agency option, the provider agency and individual are responsible for developing an implementation plan that describes the type of service, the type of service provider, the schedule of services, the location of service provision, and the amount of services provided to the individual. The implementation plan must also explain the strategies for assisting the individual in accomplishing his or her outcomes.

In the consumer directed service option the local intellectual and developmental disability authority service coordinator assists the consumer directed services employer in developing an implementation plan that describes the type of service, the type of service provider, the schedule of services, the location of service provision, and the amount of services provided to the individual.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-

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

The local intellectual and developmental disability authority must ensure that a service coordinator initiates, coordinates and facilitates the person-centered planning process so that an individual's person-directed plan addresses their desires and needs as identified by the individual and legally authorized representative. The service planning team consists of the individual, the individual's legally authorized representative if any, the local intellectual and developmental disability authority service coordinator, and any other persons chosen or designated by the individual or legally authorized representative to comprise the service planning team. The service planning team must develop an initial individual plan of care based on the person-directed plan for each applicant within 45 business days after the date an applicant or legally authorized representative chooses the HCS program. At least annually, the service planning team and provider agency, if applicable, must review the individual's person-directed plan and initiate changes to the individual plan of care in response to changes in the individual's needs and identified outcomes as documented in the person-directed plan. The individual and legally authorized representative must sign the individual plan of care to indicate agreement with the plan.

The service planning team must document in the person-directed plan that the HCS program service components identified for inclusion in the individual plan of care are necessary for the individual to live in the community and to prevent his or her admission to institutional services, and are sufficient, when combined with services or supports available from non-waiver resources, to ensure the individual's health and welfare in the community; are not available to the individual through any other source including the Medicaid State Plan, other governmental programs, private insurance, or the individual's natural supports; are the appropriate type and amount; and are cost effective. All third party resources, including Medicaid State Plan services, must be accessed prior to waiver services.

At a minimum, the person-directed planning process and resulting service plan must address the following:
1) A description of the needs and preferences identified by the applicant/individual, legally authorized representative, or both;
2) A description of the services and supports including the type, frequency and amount the applicant/individual requires to continue living in a community-based setting;
3) A description of the applicant/individual's current existing natural supports and non-waiver services that will be or are available;
4) A description of applicant/individual outcomes to be achieved through HCS waiver services components and justification for each service component to be included in the service plan;
5) Documentation that the type, frequency, and amount of each service component included in the applicant's/individual's service plan do not replace existing natural supports or non-waiver resources for the service components for which the applicant/individual may be eligible; and
6) A description of actions and methods to be used to reach identified service outcomes, projected completion dates, and person(s) responsible for completion.

The service coordinator ensures that the person-directed plan identifies and focuses on the desires and needs as identified by the applicant/individual and legally authorized representative, and the applicant's/individual's and legally authorized representative's assessment of the services and supports being received in relation to the applicant's/individual's needs, preferences and personal goals. Both the service coordinator and the provider agency support the individual's and legally authorized representative's participation in the service planning process by encouraging the expression of preferences, personal outcomes, and ambitions and providing education about the services available through the HCS waiver as well as through other non-waiver resources for which the individual may be qualified. In addition, formal assessments regarding health, level of functioning, and professional therapeutic interventions are completed as the need is identified by the service planning team. The person-directed plan identifies and addresses risk factors, and specifies the waiver services and non-waiver services (e.g., state plan services) to be included in the individual plan of care to address risk factors as well as the applicant's/individual's other needs, preferences and desired outcomes. The HHSC website provides service coordinators and other service planning team members access to a "Person-directed Plan Discovery Tool," which provides team members a number of probes that may be used to help identify areas of need, goals, abilities and strengths, and preferences.

At enrollment, as requested by the applicant/individual or legally authorized representative, and at least annually, the service coordinator must present information to the applicant/individual or legally authorized representative regarding available services and supports and the available service delivery options. The service coordinator must also inform the applicant/individual or legally authorized representative that the service coordinator assists the applicant/individual or legally authorized representative to transfer the applicant's/individual's HCS program services from one provider agency to another provider agency or financial management service provider to another provider agency or financial management service provider as chosen by the applicant/individual or legally authorized representative. The local intellectual and

developmental disability authority must ensure an applicant/individual or legally authorized representative is informed of the name of the individual's service coordinator and how to contact the service coordinator.

The applicant/individual and legally authorized representative, service coordinator, and other service planning team members work together to develop a person-directed plan and individual plan of care that integrates HCS services and supports and non-waiver services (e.g., state plan services) so that the individual's outcomes identified in the person-directed plan may be achieved and services are complementary and not duplicative.

An implementation plan for each waiver service identified in the person-directed plan is developed by the provider agency and the applicant/individual and legally authorized representative. The implementation plan includes a description of actions and methods used to reach identified outcomes, projected completion dates, and entity or person(s) responsible for implementing the methodology.

The individual plan of care specifies the type and amount of each service component to be provided to the applicant/individual, as well as services and supports to be provided by other, non-HCS program sources during the service plan year.

The individual's HCS provider agency is responsible for monitoring the person-directed plan. The HCS provider agency is responsible for ensuring implementation of the HCS service components it is assigned to provide, while the individual or legally authorized representative electing the consumer directed services option is responsible for ensuring implementation of self-directed services.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

During the service planning process, both the service coordinator and the HCS provider agency consider information from the individual, legally authorized representative, other service planning team members, and from assessments to determine any risks that might exist to health and welfare of the individual as a result of living in the community. Strategies, including waiver services and supports as well as formal and informal non-waiver services and supports, are developed to mitigate these risks, and are incorporated into the service plan.

The discovery process utilized by the service coordinator determines the type of services the individuals wants, as well as the individual’s desired outcomes. The service planning team identifies any needs, requests, or considerations specific to each service that are necessary to support the individual in achieving the individual’s desired outcomes.

Following the discovery process and development of the person-directed plan, the service planning team identifies and documents in the person-directed plan those services that are critical to the health and welfare of the individual for which a backup plan must be developed. Backup plans may use paid or unpaid service providers, other third-party resources, and other community resources. Back-up plans must be implemented to adequately prevent service interruptions or delays that may place the individual’s health or safety at risk.

If a service has been identified as needed to ensure health and safety of the individual but the individual or their legally authorized representative refuse the offered service, the service coordinator will monitor the individual’s health and safety through the service coordination function. A service coordinator may refer the individual to non-waiver services and supports. The Department of Family and Protective Services may be contacted if the individual's health and safety is jeopardized.

The service planning team identifies risk factors for an individual by discussing relevant areas of an individual’s life with the individual and legally authorized representative and others who provide supports to the individual and have been invited to participate in the person-centered planning process. An example of risk factors which may affect service planning might be an individual's inability to recognize the possible danger associated with certain strangers.

In the consumer directed services delivery option, the individual/employer is responsible for developing the backup plan(s). The local intellectual and developmental disability authority service coordinator determines that a service is critical to the health and safety of the individual and requests that the individual/employer develop service back-up plan(s). The service coordinator is responsible for reviewing and approving the service back-up plan(s) and any revisions to the back-up plan(s). During monitoring and at the annual service plan meeting, the service coordinator must determine if the back-up plan was implemented and effective. If the service coordinator determines that the back-up plan is ineffective, the service coordinator must notify the individual/employer of the determination and the employer must revise the back-up plan.

The individual/employer may use support consultation to assist in the development of a backup plan. The individual/employer is responsible for providing the financial management services agency with a copy of each service backup plan after it has been approved by the service coordinator.

The service coordinator must conduct and document monitoring activities, including: determining whether the individual has made progress toward the outcomes identified on the person-directed plan; determining whether HCS service(s) are being delivered, including the delivery of services included in backup plans, as needed, by the provider agency or consumer directed services direct service provider, as appropriate; determining whether non-waiver services are being delivered; ensuring coordination and compatibility of waiver and non-waiver services with the provider agency; and determining whether the individual's health or safety is at risk in the environments where the individual receives waiver and non-waiver services and, if necessary, taking action to protect the individual's health and safety. Action may include addressing the risk with the provider agency or notifying the appropriate authorities.

If, as a result of monitoring, the service coordinator identifies a concern with an individual's progress toward outcomes in the person-directed plan, the delivery of HCS services, including implementation of the backup plan, or the individual's health and safety, the service coordinator must communicate such concern to the HCS provider agency via a mechanism determined by the local intellectual and developmental disability authority and HCS provider agency. The service coordinator and the HCS provider agency are responsible for resolving any identified concern. If the concern cannot be resolved, the service coordinator may report the concern to IDD Ombudsman.

Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D, §9.177 requires the HCS provider agency to

ensure the continuous availability of trained and qualified employees and contractors to provide the services in an individual service plan.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Rules governing the HCS program (Title 26 of the Texas Administrative Code, Part 1, Chapter 263, Subchapter B) requires a local intellectual and developmental disability authority, when processing the applicant's enrollment in the HCS program, to:
(A) provide a list to the individual or legally authorized representative with contact information for all provider agencies in the local intellectual and developmental disability authority's local service area;
(B) arrange for meetings/visits with potential provider agencies as requested by the applicant or the legally authorized representative; and
(C) ensure that the applicant's or legally authorized representative's choice of a provider agency is documented, signed by the individual or the legally authorized representative, and retained in the applicant's/individual's record;

In accordance with all local intellectual and developmental disability authority performance contracts, local intellectual and developmental disability authorities are required to ensure their enrollment staff are objective in assisting an individual or legally authorized representative in selecting a program provider or financial management services agency and not influence the individual's or legally authorized representative's decision. The local intellectual and developmental disability authority provides meaningful access to its programs, services, and activities and ensures adequate communication through language assistance services for legally authorized representatives of individuals under 22 years old with limited English proficiency, sensory impairments, and/or speech impairments. The performance contract also prohibits a local intellectual and developmental disability authority's own provider agency staff from initiating contact with the applicant/individual or legally authorized representative prior to their choice of provider agency or financial management services agency.

At the time of enrollment and upon request, the service coordinator provides the individual or legally authorized representative with a list of all qualified provider agencies in the individual's service area. The service coordinator may also refer the individual or legally authorized representative to resources provided by HHSC to assist them in the selection of a provider agency. These resources include the HHSC Long-Term Provider Search website. This website includes a list of all qualified provider agencies that is searchable by city, county, or zip code and includes provider agency contact information, current census, and HHSC Long-Term Care Regulation reviews results. HHSC has also posted on its website an optional tool for individuals and their families to use during the process of provider agency selection.

Local intellectual and developmental disability authorities are required to provide service coordination in accordance with the HCS certification principles located in Title 40 of the Texas Administrative Code, Chapter 9, Subchapter D; Chapter 2, Subchapter L, and Chapter 41 which require an individual's service coordinator to manage the process to transfer the individual's HCS services from one program provider to another or one financial management services agency to another in accordance with HHSC instructions. At least annually, the service coordinator must inform the individual or legally authorized representative of their rights.

HHSC Contract Accountability and Oversight conducts annual local intellectual and developmental disability authority performance contract reviews to assess local intellectual and developmental disability authority compliance with contract provisions.

During all local intellectual and developmental disability authority performance contract reviews and program provider certification reviews, HHSC examines evidence of the local intellectual and developmental disability authority's and the program provider's compliance with safeguarding the right of individuals and legally authorized representatives to exercise free choice of program providers and the right to transfer to a new program provider. HHSC assesses this compliance through individual and legally authorized representative interviews and through a review of individual records. Service coordinators and program provider are also required to inform individuals and legally authorized representatives of the process for filing a complaint with The IDD Ombudsman, and must provide them with the phone number for The IDD Ombudsman. The IDD Ombudsman follows up on all complaints received related to HCS, including those related to an individual's or legally authorized representative's right to choose from among the list of qualified providers, to ensure an individual's rights are protected.

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 reviews and approves all individual plans of care in the HCS waiver. HHSC also reviews each provider agency's compliance with the service planning requirements, as well as the local intellectual and developmental disability authority's compliance with the service planning requirements. HHSC's Long-Term Care Regulation division performs at least annual certification reviews of each provider agency during which they review the provider agency's compliance with the service planning requirements. HHSC's Contract Accountability and Oversight unit performs annual local authority performance contract reviews during which they review the local intellectual and developmental disability authority's compliance with the service planning requirements.

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:

Provider agency and local intellectual and developmental disability authority.

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.

Provider agencies monitor implementation of service plans and individuals' health and welfare and assess how well services are meeting an individual's needs and enabling the individual to achieve the specific objectives described in the service plan. The provider agency must ensure that waiver services identified in the individual's implementation plan are provided in an individualized manner and are based on the results of assessments of the individual's and the family's strengths, the individual's personal goals and the family's goals for the individual, and the individual's needs. The provider agency must ensure that each individual's progress or lack of progress toward desired outcomes is documented in observable, measurable, or outcome-oriented terms. The program provider must maintain a system of delivering waiver services that is continuously responsive to changes in the individual's personal goals, condition, abilities, and needs as identified by the service planning team.

The local intellectual and developmental disability service coordinators monitor an individual's progress toward the achievement of desired outcomes identified in the person-directed plan and monitor the individual's continued access to non-waiver supports, as necessary, for the individual to reside successfully in the community. Service coordinators determine whether waiver services are being provided and ensure the individual or legally authorized representative are afforded free choice of provider agencies upon enrollment and when a transfer is requested or when the individual moves without prior notice. The service coordinator and provider agency take appropriate actions to address identified problems, including convening a meeting to resolve problems; or advocating on the individual's behalf as necessary.

The local intellectual and developmental disability service coordinators are required to have face-to-face contact with the individual's at least every 90 calendar days or more frequently as necessary. When monitoring identifies changes in the individual's needs or preferences, the local intellectual and developmental disability authority service coordinator convenes a service planning team meeting with the provider agency to address the needed changes and revise the service plan. A revision to the service plan is made in conjunction with the local intellectual and developmental disability authority service coordinator, individual or legally authorized representative, and others as chosen by the legally authorized representative.

At least annually and as the individual's needs change, the local intellectual and developmental disability service coordinator or provider agency is responsible for reviewing the individual's service backup plan, developed by the consumer directed services employer or provider agency.

For a back-up plan developed by the provider agency, the provider agency is responsible for reviewing the back-up plan at least annual and as the individual's needs change and ensuring the back-up plan was effective if it was implemented. If the service coordinator is notified by the individual or legally authorized representative that a backup plan is not effective, the service coordinator will notify the provider agency, and the provider agency will revise the back-up plan as necessary.

For a back-up plan developed by the consumer directed services employer, is responsible for reviewing the back-up plan at least annually and as the individual's needs change and ensuring the back-up plan was effective if implemented. If the service coordinator is notified by the consumer directed services employer or legally authorized representative that a back-up plan is not effective, the service coordinator will assist the consumer directed services employer with revising the back-up plan as necessary.

If the person directed planning process reveals that an individual has a need for health services or acute care services, the service coordinator is responsible for ensuring appropriate waiver and non-waiver services are included in the service plan to address the need and that the individual's health needs are being addressed by the provider agency or MCO, as necessary.

During reviews and surveys, HHSC ensures that the service plans were developed in accordance with the service planning process described in Title 26 of the Texas Administrative Code, Part 1, Chapter 263, Subchapter D, including that the individual or legally authorized representative agreed to the service plan. Through these reviews HHSC also ensures that service plans are implemented and then monitored in accordance with HCS certification principles. HHSC annually and quarterly aggregates the data. HHSC discusses any significant findings and if necessary develops a corrective action plan to implement.

b. Monitoring Safeguards. *Select one:*

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

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

The provider agency is responsible for providing the full array of waiver services to the individual as necessary to meet their individual support needs. The provider agency is responsible for monitoring the delivery of waiver services, as described in D-1-d of this appendix to ensure they are provided in accordance with the service plan.

The local intellectual and developmental disability service coordinator is responsible for determining whether the individual's health or safety is at risk in the environments where the individual receives waiver and non-waiver services and, if necessary, taking action to protect the individual's health and safety. For HCS waiver services, action may include addressing the risk with the provider agency or notifying the appropriate authorities. For consumer directed services, action may include the development of a plan of correction with the consumer directed services employer and follow-up monitoring to determine if the consumer directed services option can ensure the individual's health and safety or notifying the appropriate authorities.

HHSC performs on-site certification reviews of each provider agency and performance contract reviews of each local intellectual and developmental disability authority at least annually. A sample of individuals receiving HCS waiver services from the provider agency are interviewed and records are reviewed to determine if the provider agency followed service planning requirements, including that the individual’s needs are being met, service plans change as needs change, and the individual’s best interests are served. A sample of records of individuals in the HCS waiver that are receiving service coordination from the local intellectual and developmental disability authority are reviewed to determine that the local intellectual and developmental disability authority is following HCS service planning requirements, including that the individuals' needs are being met and service plans change as needs change. In addition, records are reviewed to ensure compliance with the right of individuals, and legally authorized representatives, to exercise free choice of provider agencies and the right to transfer to a new provider agency.

Following the initial certification, HHSC Long-Term Care Regulation evaluates a provider agency’s compliance with the HCS certification principles during annual recertification surveys. If a provider agency is determined to be in compliance with all certification principles, HHSC Long-Term Certification Regulation certifies the provider agency for a period of no more than 365 calendar days.

HHSC may conduct announced or unannounced reviews of the provider agency at any time.

HHSC conducts, at least annually, unannounced surveys of each residence in which residential support or supervised living is provided to verify that the residence provides an environment that is healthy and safe for the individuals who live there and complies with HHSC rules. HHSC may, at any time, conduct an unannounced survey of a residence in which host home/companion care is provided to determine if the residence provides an environment that is healthy and safe for the individuals who live there and complies with HHSC rules.

The provider agency and local intellectual and developmental disability authority are required to inform individuals and legally authorized representatives, both orally and in writing, of the process for filing a complaint with the HHSC Intellectual and Developmental Disability Ombudsman (IDD Ombudsman), and must provide them with the phone number for the IDD Ombudsman . Evidence of compliance with this requirement is also assessed during all performance contract reviews conducted by HHSC. The IDD Ombudsman conducts an investigation of all complaints received, other than those for abuse, neglect, or exploitation, to ensure individuals’ rights are protected. The complaints that may be directed to the IDD Ombudsman include those related to individuals’ or legally authorized representatives’ right to choose from among the list of qualified provider agencies.

The provider agency and the local intellectual and developmental disability authority service coordinator have the shared responsibility to ensure individuals' rights are protected, service plan monitoring occurs as required by the HCS rules, required documentation is completed, and appropriate follow-up action on review findings is taken.

Local intellectual and developmental disability authorities who contract with HHSC to provide HCS services must ensure that the HCS program operation is organizationally separate from the access and intake operations and that service coordinators do not provide provider agency functions.

HHSC Contract and Accountability Oversight reviews the local intellectual and developmental disability authority annually through performance contract reviews to ensure that enrollment, service coordination, and continuity of care functions are conducted in the best interests of the individual. HHSC monitoring elements include verification of freedom of choice of provider agencies, verification that a complete list of available provider agencies have been

given to individuals and that individuals are informed no less than annually of their right to choose another provider agency at any time by requesting assistance from their local intellectual and developmental disability authority service coordinator.

HHSC utilizes the Adverse Action Review Committee (composed of a cross-departmental group of HHSC staff) if HHSC review staff recommend a discretionary sanction involving vendor hold or termination of a program provider's Medicaid provider agreement. The Adverse Action Review Committee provides an objective review of each referral for action or sanction against a provider agency and renders an unbiased decision in the case. HHSC can also assess administrative penalties for critical violations issued in a Long-Term Care Regulation survey.

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.1 Number and percent of surveyed contracts that include individuals with service plans that address their assessed needs, including health and safety risk factors and personal goals. N: Number of surveyed contracts that include individuals with service plans that address their assessed needs, including health and safety risk factors and personal goals. D: Number of surveyed contracts.

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

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

☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Approximately 25% of active contracts are reviewed each quarter, for a 100% review of contracts per waiver year. A random sample of individual service plans are evaluated during each contract survey.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

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.1 Number and percent of service plans that were reassessed and renewed annually prior to the service plan expiration date. N: Number of service plans that were reassessed and renewed annually prior to the service plan expiration date. D: Number of service plans that required annual reassessment and renewal.

Data Source (Select one):
Other

If 'Other' is selected, specify:

Quality Assurance and Improvement Data Mart

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

Data Aggregation and Analysis:

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

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

Performance Measure:
D.c.2 Number and percent of surveyed contracts that include individuals service plans that addressed the individual's ongoing needs. N: Number of surveyed contracts that include individuals with service plans that addressed the individual's ongoing needs. D: Number of surveyed contracts.

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

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

	Ongoing	Specify: Approximately 25% of active contracts are reviewed each quarter, for a 100% review of contracts per waiver year. A random sample of individual service plans are evaluated during each contract survey.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 surveyed contracts that include individuals with records that reflected services were delivered according to their service plan. N: Number of surveyed contracts that include individuals with records that reflected that services were delivered according to their service plan, including type, scope, amount, duration, and frequency. D: Number of surveyed contracts.

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

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

		Approximately 25% of active contracts are reviewed each quarter, for a 100% review of contracts per waiver year. A random sample of individual service plans are evaluated during each contract survey.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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.1 Number and percent of individuals with reviewed records who were afforded choice among waiver providers. N: Number of individuals with reviewed records who were afforded choice among waiver providers. D: Number of individuals with reviewed records.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Contract Accountability and Oversight Performance Contract reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: The agency reviews records of 5 individuals receiving HCS for each of the 39 LIDDAs.

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.e.2 Number and percent of individuals with reviewed records who were afforded choice between and among waiver services. N: Number of individuals with reviewed records who were afforded choice between and among waiver services. D: Number of individuals with reviewed records

Data Source (Select one):
Other
If 'Other' is selected, specify:
Contract Accountability and Oversight Performance Contract reviews

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

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: The agency reviews records of 5 individuals receiving HCS for each of the 39 LIDDAs.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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 Long-Term Care Regulation continuously reviews 100 percent of provider agencies annually. A random sample of individual records are reviewed annually during HHSC Long-Term Care Regulation certification reviews. The data is aggregated and analyzed for the quarter in which the program provider is monitored.

Based upon a directive issued by the HHSC Executive Commissioner, HHSC has a process which requires quarterly and annual reports. The reports include data relating to all performance measures in the waiver which include service plan development and monitoring. All quarterly and annual reports are reviewed by HHSC. Quarterly and annual reporting allows the State to identify additional areas of remediation that require training or technical assistance based on performance measure reports that are representative of the waiver population. If issues are identified, HHSC employs a variety of mechanisms to resolve issues including informal conversations, elevated conversations, issuing an action memo, or issuing a corrective action plan.

HHSC has a process in place for the review and approval of any policy changes concerning the waivers. All policy changes, including any changes to the service planning process and program provider agency monitoring, must be reviewed by HHSC prior to implementation.

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.

Provider Agencies
If HHSC Long-Term Care Regulation determines after an initial or annual survey that the provider agency is in compliance with all certification principles, HHSC certifies the provider agency.

If HHSC Long-Term Care Regulation determines from a survey that the provider agency is not in compliance with the certification principles, the provider agency must submit a plan of correction (POC) for each violation identified by HHSC in the final survey report. The POC must:
• Specify the corrective action to be taken for those individuals affected by the deficient practice;
• Explain how other individuals with the potential to be affected by the same deficient practice will be identified;
• Identify measures to be put in place or systemic changes to be made to ensure the deficient practice will not recur;
• Provide how corrective action will be monitored to ensure the deficient practice is being corrected and will not recur; and
• Specify the date corrective action will be completed for each violation. For a critical violation, the date must be no later than 30 calendar days, or 45 calendar days for a non-critical violation, after the survey exit conference.

If HHSC approves the POC, the provider agency must complete the specified corrective action. If HHSC does not approve the POC, the provider agency must submit a revised POC. If the provider agency does not submit a POC or revised POC, or if HHSC notifies the provider agency that a revised POC is not approved, HHSC imposes a vendor hold against the provider agency until HHSC approves the POC or denies or terminates certification of the provider agency.

If HHSC approved a POC, HHS takes the following actions to determine if a provider agency has completed corrective action:
- request that the provider agency submit evidence of correction to HHSC; and
- conduct a survey:
  - A survey is conducted after the date specified in the POC for correcting the violation but within 45 days after the survey exit conference for critical violations. For a non-critical violation, the survey is conducted at least 46 days after the survey exit conference, unless the provider agency requests an earlier follow-up survey as allowed in state rule.

HHSC may impose and collect an administrative penalty against a provider agency for a violation of a certification principle or for any of the following: making a false statement of a material fact the provider agency knows or should know is false with respect to a matter under investigation by HHSC; falsifying documentation; willfully interfering with the work of a representative of HHSC; or failing to pay an administrative penalty within 10 calendar days after the date the assessment of the penalty becomes final.

If HHSC implements a vendor hold against the provider agency with a standard contract, HHSC conducts a second on-site follow-up review at least 31 calendar days after the effective date of the vendor hold. Based on the results of the review, HHSC may certify the provider agency and recommend removal of the vendor hold or may recommend further contract action such as denial or termination of the provider agency's contract. If HHSC implements a vendor hold against a provider agency with a provisional contract, HHSC may initiate contract termination.

HHSC annual monitoring includes reviewing data from quarterly quality measures and annual 372 reports and implementing the Quality Review Team (QRT) processes. The Quality Review Team meets quarterly and reviews quality reports from each waiver at least annually. These reports include data on all of the waivers' quality improvement strategies and remediation outcomes. Improvement plans are developed as issues are identified, and the QRT reviews, and approves all improvement plans, modifying as needed. All active improvement plans for all waivers are monitored at each QRT meeting.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Participation in the consumer directed services option provides the individual or the legally authorized representative the opportunity to be the employer of persons providing those waiver services chosen for self-direction. If the individual has a legally authorized representative, the legally authorized representative must be serve as the CDS employer on the individual's behalf.

An individual, through the consumer directed services option, may direct supported home living, respite, nursing, cognitive rehabilitation therapy, supported employment, employment assistance, or any combination of these services. This option is available statewide to individuals receiving HCS waiver services who are living in their own homes, family homes, or legally authorized representatives' homes.

The traditional agency option is available to provide authorized services that the individual or legally authorized representative elects not to self-direct. Under the traditional agency option, individuals choose a certified and contracted HCS provider agency capable of delivering the full array of HCS program service components.

Each individual or legally authorized representative electing the consumer directed services option must receive support from a financial management services provider referred to as a financial management services agency chosen by the individual or legally authorized representative. The individual or the legally authorized representative is the employer and may appoint a designated representative to assist with employer responsibilities. The individual or legally authorized representative may choose to receive support consultation provided by a support advisor. The individual or legally authorized representative must go to the local intellectual and developmental disability authority service coordinator for assistance with their service plan, implementation plan, service back-up plans, and other required documentation for all services chosen to be consumer directed services. An individual or legally authorized representative may also receive support consultation, which is available only to individuals who choose the consumer directed services option.

The individual or the legally authorized representative may appoint a designated representative to assist with or perform employer responsibilities to the extent approved by the employer. HHSC will not pay the individual/employer's designated representative for serving as the designated representative or for providing any services to the individual.

When choosing to self-direct authorized waiver services, the individual receiving those services, or their legally authorized representative, is the common-law employer of service providers and has decision-making authority over providers of those services. The employer or designated representative, with the assistance and final approval of the financial management services agency, budgets authorized funds for those services to be delivered through the consumer directed services option. HHSC authorizes the funds for the services allocated for the consumer directed services option on the service plan.

Support consultation is an optional service available to provide assistance and skills training for the employer or designated representative in meeting employer responsibilities and succeeding in the consumer directed services option. If support consultation is authorized by the individual's service planning team, the employer or designated representative may receive this service from a support advisor associated with a financial management services agency or from a qualified independent support advisor.

The service coordinator informs the individual and legally authorized representative of the option to self-direct available waiver services at the time of enrollment in the waiver, and at least annually thereafter. The individual or legally authorized representative may elect at any time to choose the consumer directed services option, terminate participation in the consumer directed services option, or to change financial management services agencies.

Entities or individuals involved in supporting participants or participants' legally authorized representatives who are directing services and supports include:

- The individual or legally authorized representative, as the employer, may appoint an adult as a designated representative to assist in meeting employer responsibilities to the extent directed by the employer;
- The individual's service coordinator provides information about the consumer directed services option and monitors service delivery. The functions provided by service coordinators are more global than those of the support advisor and apply to self-directed as well as agency-directed waiver services and non-waiver services.
- A third-party entity, a financial management services agency, chosen by the individual or legally authorized representative, provides financial management services. The financial management services agency must hold a Medicaid provider agreement with HHSC.
- A support advisor provides support consultation services. Support consultation offers skills training and assistance

related to the individual's responsibilities as an employer, to help the individual participate successfully in the consumer directed services option.
• The individual employer has the option to receive support consultation from a certified support advisor of their choice, when authorized in the individual's service plan, to assist in learning about and performing employer responsibilities; and
• A designated representative, if appointed by the individual or legally authorized representative, who assists in meeting employer responsibilities to the extent directed by the employer;

To participate in the consumer directed services option, an individual or legally authorized representative must:
(1) Select a financial management services agency;
(2) Participate in orientation and ongoing training conducted by the financial management services agency;
(3) Perform all employer tasks that are required for self-direction or designate a designated representative capable of performing some or all of these tasks on the individual or legally authorized representative's behalf; and
(4) Maintain a service backup plan for provision of services determined by the service planning team to be critical to the individual's health and welfare.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

  Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who**

decide not to direct their services.

◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Individuals receiving HCS waiver services are offered the opportunity to self-direct services when:

1. They live in their own homes, the homes of family members, or the legally authorized representative's homes; and
2. Their service plan includes supported home living, respite, supported employment, employment assistance, cognitive rehabilitation therapy, or nursing services.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

When an individual enrolls in the waiver, a local intellectual and developmental disability authority service coordinator provides the individual and legally authorized representative with a written and oral explanation of the consumer directed services option. Subsequent to enrollment, the service coordinator presents the information and the opportunity to participate in consumer directed services to the individual, who do not receive the following residential services: host home/companion care, residential support services, or supervised living, at least annually and upon request.

Each individual or legally authorized representative is provided information sufficient to assure informed decision-making and understanding of the consumer directed services option and of the traditional provider-managed service delivery option. The information includes the responsibilities and choices individuals can make with the election of the consumer directed services option.

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

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☐ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The individual or the legally authorized representative, serving as the consumer directed services employer, may appoint an adult who is not the legally authorized representative as a designated representative to assist in performance of employer responsibilities to the extent desired by the individual or legally authorized representative. The consumer directed services employer documents the employer responsibilities that the designated representative may perform and those that the designated representative may not perform on the consumer directed services employer's behalf. The consumer directed services employer provides this documentation to the financial management services agency. The financial management services agency monitors performance of employer responsibilities performed by the individual/employer and, when applicable, the designated representative in accordance with the individual's/employer's documented directions. Neither the designated representative nor the spouse of the designated representative may be employed by, receive compensation from, or be the provider of waiver services for the individual. The consumer directed services employer may terminate the responsibilities of the designated representative at any time.

To ensure the designated representative functions in the best interests of the individual, safeguards are in place that include restrictions preventing the designated representative from:
-signing or representing himself as the employer;
-providing a waiver service; or
-being paid to perform employer responsibilities.

Applicants for employment are required to certify the status of the relationship with the employer. If the person indicates that he or she is either a designated representative or designated representative's spouse, the financial management services agency would not approve the applicant for hire. The financial management services agency maintains documentation of the designated representative. HHSC monitors compliance during the financial management services agency contract monitoring.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Nursing	☒	☒
Support Consultation	☒	☒
Supported Employment	☒	☒
Supported Home Living	☒	☒
Respite	☒	☒
Employment Assistance	☒	☒

Waiver Service	Employer Authority	Budget Authority
Cognitive Rehabilitation Therapy	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Financial Management Services

○ **FMS are provided as an administrative activity.**

Provide the following information

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

Private entities furnish financial management services. These entities, called financial management services agencies, are procured through an open enrollment process and the State has Medicaid provider agreements with multiple entities to provide financial management services to individuals across the state.

HHSC executes a Medicaid provider agreement with each financial management services agency.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Entities are compensated with a flat monthly fee per individual.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☒ **Other**

Specify:

Obtain criminal history check on behalf of consumer directed services employer and shares information with the consumer directed services employer so the employer can make a hiring decision.

Supports furnished when the participant exercises budget authority:

☒ **Maintain a separate account for each participant's participant-directed budget**

☒ **Track and report participant funds, disbursements and the balance of participant funds**

☒ **Process and pay invoices for goods and services approved in the service plan**

☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

Specify:

Additional functions/activities:

☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

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

HHSC conducts monitoring reviews of financial management services agencies to determine if the financial management services agencies are in compliance with the Medicaid provider agreement and with HCS and CDS rules and requirements. These reviews are conducted via desk review or at the location where the financial management services agency is providing financial management services.

HHSC monitors 100 percent of the financial management services agencies at a minimum every three years.
HHSC assesses a financial management services agency's performance by:
(1) Measuring adherence to rules as described in Title 40 of the Texas Administrative Code, Part 1, Chapter 41;
(2) Matching payroll, optional benefits, and tax deposits to time sheets;
(3) Ensuring that the hours worked and rate of pay are consistent with individual budgets;
(4) Reviewing administrative payments; and
(5) Reviewing the service agreements.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Local intellectual and developmental disability authority service coordinator through targeted case management are responsible for providing each individual or legally authorized representative information sufficient to assure informed decision-making and understanding of the consumer directed services option and of the traditional provider-managed service delivery option. The information includes the responsibilities and choices individuals can make with the election of the consumer directed services option. Local intellectual and developmental disability authority service coordinator review the consumer directed services option at waiver enrollment, at least annually, and upon request.

Information provided orally and in writing to the individual and the legally authorized representative by the local intellectual and developmental disability authority service coordinator includes:
1. An overview of the consumer directed services option;
2. Explanation of responsibilities of the individual or individual's legally authorized representative and the financial management services agency in the consumer directed services option;
3. Explanation of benefits and risks of participating in the consumer directed services option;
4. Self-assessment for participation in the consumer directed services option;
5. Explanation of required minimum qualifications of service providers through the consumer directed services option; and
6. Explanation of employee/employer relationships that prohibit employment under the consumer directed services option.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services)	☐
Occupational Therapy	☐
Nursing	☐
Transition Assistance Services	☐
Support Consultation	☒
Dietary Services	☐
Dental Treatment	☐
Supported Employment	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Supported Home Living	☐
Physical Therapy	☐
Audiology	☐
Respite	☐
Employment Assistance	☐
Behavioral Support	☐
Cognitive Rehabilitation Therapy	☐
Individualized Skills and Socialization	☐
Minor Home Modifications	☐
Speech and Language Pathology	☐
Adaptive Aids	☐
Financial Management Services	☒
Social Work	☐
Prescribed Drugs	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

An individual or legally authorized representative may voluntarily terminate participation in the consumer directed services option at any time. The local intellectual and developmental disability authority service coordinator and provider agency, if applicable, assists the individual in revising the service plan (specifically, the individual plan of care and the person-directed plan) for the transition of services previously delivered through the consumer directed services option to be delivered by the provider agency chosen by the individual or legally authorized representative. The provider agency assists the individual as necessary to ensure continuity of all waiver services through the traditional agency service delivery option (provider-managed service delivery) and maintenance of the individual's health and welfare during the transition from the consumer directed services option.

The financial management services agency closes the employer's payroll and payable accounts and completes all deposits and filings of required reports with governmental agencies on behalf of the individual. The local intellectual and developmental disability authority service coordinator and provider agency assist the individual to begin services through the service provider option with no gap in coverage. The individual must wait 90 days before returning to the consumer directed services option.

The provider agency, selected by the individual, works with the service planning team to revise the service plans so that services can be delivered by the service provider without delay. The provider agency assists the individual as necessary to ensure that there are no gaps in services during the transition from the consumer directed services option.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

The local intellectual and developmental disability authority service coordinator, the provider agency, the financial management services agency, or HHSC may recommend termination of the consumer directed services option if the individual, legally authorized representative, or designated representative does not implement or successfully complete the following steps and interventions:

1. Address the risk to the individual's health or welfare;
2. Successfully direct the delivery of appropriate program services through the consumer directed services option;
3. Meet employer responsibilities as listed in E-2-a(ii), Participant-Employer Authority, and E-2-b(i), Participant-Budget Authority;
4. Successfully implement corrective action plans; or
5. Appoint a designated representative or access other available help to assist the employer in meeting employer responsibilities.

HHSC may require immediate termination from consumer direction in circumstances that jeopardize the individual's health and welfare when the designated representative who is not a relative is convicted of a barrable offense, or if another regulatory agency recommends termination.

The local intellectual and developmental disability authority service coordinator and provider agency, if applicable, assist the individual in revising the service plan for the transition of services previously delivered through the consumer directed services option to be delivered by the provider agency chosen by the individual or legally authorized representative. The local intellectual and developmental disability authority service coordinator and the provider agency assist the individual to ensure continuity of all waiver services through the traditional provider-managed service delivery option and maintenance of the individual's health and welfare during the transition from the consumer directed services option. The financial management services agency closes the employer's payroll and payable accounts and completes all deposits and filing of required reports with governmental agencies on the individual's behalf.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		1341
Year 2		1341
Year 3		1341
Year 4		1341
Year 5		1341

Appendix E: Participant Direction of Services

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

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

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

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of

participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

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

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

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

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

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

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

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

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

Specify:

Reallocate funds among services included in the budget by requesting a service planning team meeting and revision to the individual plan of care.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The service plan is developed in the same manner for the individual who elects the consumer directed services option as it is for the individual who elects to have services delivered through the traditional provider-managed option. HHSC must authorize the individual plan of care and the estimated cost of waiver services. The consumer directed budget is the estimated cost of the self-directed services in the approved individual plan of care and the adopted consumer directed services reimbursement rates. The consumer directed budget is developed by the individual or legally authorized representative with assistance from the financial management services agency.

The consumer directed budget is allocated to each self-directed service based on the approved service plan. The budget for each service, and any revisions, must be approved by the financial management services agency prior to implementation. The financial management services agency must ensure that projected expenditures are within the authorized budget for each service, are allowable and reasonable, and are projected over the effective period of the plan to ensure that sufficient funds will be available to the end date of the service plan. With approval of the financial management services agency, the individual or legally authorized representative may make revisions to a specific service budget that does not change the amount of funds available for the service based on the approved service plan.

Employer-related costs are paid for through the consumer directed services rates and include costs for equipment, supplies, or activities that will provide direct benefit to the individuals who self-direct services to support specific outcomes related to being an employer including but not limited to: recruiting expenses, fax machine for sending employee time sheets to the financial management services agency, criminal conviction history checks from the Texas Department of Public Safety, acquiring other background checks of a potential service provider, purchased employee job-specific training, and Hepatitis B vaccination, if elected by an employee.

Support consultation has a specific reimbursement rate and is a component of the individual's service budget. In conjunction with the local intellectual and developmental disability authority service coordinator and provider agency, if applicable, the individual or legally authorized representative determines the level of support consultation necessary for inclusion in each individual's service plan.

Revisions to the budget for a particular service or a request to shift funds from one self-directed waiver service to another requires a revision to the individual plan of care, and must be justified by the revision of the person-directed plan and individual plan of care and authorized by HHSC. With assistance from the financial management services agency, the individual or legally authorized representative revises the consumer directed services budget to reflect a revision in the individual plan of care.

Information concerning budget methodology for the consumer directed services budget is available to the public in Title 40 of the Texas Administrative Code, Part 1, Chapter 41, Subchapter E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The individual or legally authorized representative participates with the local intellectual and developmental disability authority service coordinator and provider agency, if applicable, in the development of the individual plan of care. The individual and legally authorized representative are involved in the service planning development process and are apprised of the budget as it is developed. The individual develops the consumer directed services budget based on the finalized service plan and authorized budget.

The individual may request an adjustment to the budget at any time, subject to cost ceilings. When HHSC denies an individual's request for an adjustment to the budget or reduces the budget, the individual is entitled to a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A. The specific procedures for a fair hearing are provided in Appendix F, Individual Rights.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

An individual's consumer directed budget is calculated and monitored based on projected utilization and frequency of the service as determined by the development of the implementation plan. The financial management services agency is required to monitor payroll every pay period (two weeks) and expenditures (as processed for payment) and report over- and under-utilization to the employer and the service coordinator. When an over- or under-utilization is not corrected by the employer, the financial management services agency notifies the individual's local intellectual and developmental disability authority service coordinator and the employer. The local intellectual and developmental disability authority service coordinator and the employer identify the cause of continuing deviation from projected utilization and develop a plan to correct the deviation or revise the service plan.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

At enrollment, upon revision of the "Your Rights in the Home and Community-based Services Program" booklet, at the individual's or legally authorized representative's request, or if there is a change in the individual's legal status, a local intellectual and developmental disability authority service coordinator provides the individual, legally authorized representative, or family member, a copy of the handbook, "Your Rights in the Home and Community-based Service Program," and an oral explanation of the rights described in the handbook. The handbook includes information about the individual's right to request a fair hearing in the Home and Community-based Services Program.

If Home and Community-based Services Program services are reduced, denied, suspended or terminated an individual is entitled to request a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A. If the individual's services are reduced, denied, or terminated, HHSC sends a letter to the individual describing the action HHSC has taken or will take and gives the individual the right to request a fair hearing.

Individuals will be afforded the opportunity to request a fair hearing in all instances where they are not allowed to select an HCS service provider from a list of all available HCS service providers within the geographic area in which they receive waiver services.

Individuals will be afforded the opportunity to request a fair hearing in all instances where they are denied the service(s) of their choice.

Individuals will be afforded the opportunity to request a fair hearing in all instances where they are not notified that they have the choice of receiving HCBS instead of institutional services.

If an individual's services are reduced, suspended, or terminated, HHSC sends a letter to the individual at least 10 days prior to the effective date of action in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A, §357.11, except as permitted in situations described in Title 42, Code of Federal Regulations §431.213 and §431.214.

HHSC retains a copy of the letter and if an individual or legally authorized representative elects to request a fair hearing, HHSC retains a copy of the written request for a hearing.

An individual whose services are reduced, suspended, or terminated will continue to receive services while the fair hearing process is pending if the request for a hearing is received by HHSC before the effective date of action.

If an individual requests a fair hearing, HHSC enters the information into the Texas Integrated Eligibility Redesign System for notification to the HHSC Fair Hearings Office that conducts fair hearings. HHSC maintains a hard copy folder of all appeals it conducts. Fair hearing requests are tracked in the HCS Database and in the Texas Integrated Eligibility Redesign System creating an electronic record of the request.

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, the single State Medicaid Agency.

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

The Intellectual and Developmental Disability Ombudsman (IDD Ombudsman) receives complaints from individuals, legally authorized representatives, family members, and the general public, regarding HCS service provisions and service coordination. The IDD Ombudsman ensures that all contacts are handled in a timely and professional manner. All complaints received are acknowledged. HHSC advises complainants that the formal filing of a complaint is not required and is not a substitute for the applicant/individual requesting a fair hearing if enrollment or services are denied, reduced, suspended, or terminated.

Complaints can be submitted by telephone by calling a toll-free line, by e-mail, or by written correspondence. IDD Ombudsman answer the toll-free line from 8 a.m. to 5 p.m. Monday through Friday. Complaints may be anonymous. The identity of all complainants and individuals is protected by law. The IDD Ombudsman investigates and works to resolve the complaint within 10 business days after receiving the complaint, unless the complaint involves abuse, neglect, or exploitation of an individual receiving services. Resolution of complaints is tracked and recorded in the IDD Ombudsman complaint database. If the IDD Ombudsman is unable to resolve a complaint, it is referred to the appropriate area within HHSC. When IDD Ombudsman staff determines HHSC has no jurisdiction to investigate, complaints are referred to other agencies, boards, or entities as applicable. Complaints involving allegations of abuse, neglect, or exploitation are referred immediately, but not later than one hour after receipt of the complaint, to the Texas Department of Family and Protective Services Statewide Intake, and are investigated by Department of Family Protective Services or HHSC.

A local intellectual and developmental disability authority must ensure that, upon enrollment and annually thereafter, an individual or legally authorized representative is informed orally and in writing of the telephone number of the local intellectual and developmental disability authority to file a complaint; the toll-free telephone number of the IDD Ombudsman to file a complaint; and the toll-free telephone number of Department of Family Protective Services Statewide Intake to report an allegation of abuse, neglect, or exploitation.

A provider agency must inform the individual or legally authorized representative how to report allegations of abuse, neglect, or exploitation before or at the time the individual begins receiving services and at least annually thereafter. The provider agency is also required to report a complaint to HHSC or the local intellectual and developmental disability authority when the provider agency's resolution of a complaint is unsatisfactory to the individual or legally authorized representative, including the IDD Ombudsman hotline, to initiate complaints, as well as the local intellectual and developmental disability authority telephone number to initiate complaints.

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 provider agency personnel, local intellectual and developmental disability authority staff, individuals, and financial management services agencies are provided the Texas Department of Family and Protective Services Statewide Intake toll-free telephone number in writing and are instructed to report to the Department of Family and Protective Services Statewide Intake hotline immediately, but not later than one hour after having knowledge or suspicion that an individual has been or is being abused, neglected, or exploited.

The provider agency must report the death of an individual to the local intellectual and developmental disability authority and HHSC by the end of the next business day following the death of the individual or the provider agency’s knowledge of the death. If the provider agency reasonably believes that the individual's legally authorized representative does not know of the individual's death, the provider agency notifies the individual's legally authorized representative as soon as possible, but not later than 24 hours after the provider agency learns of the individual's death.

A service provider must enter the following critical incident data in the HHSC data system no later than the last calendar day of the month that follows the month being reported in accordance with the HCS Provider User Guide:

- Medication errors committed by provider agency staff or occurring under the supervision of provider agency staff;
- Serious physical injuries;
- Total number of deaths;
- Unusual deaths;
- Total number and types of restraints;
- Number of 911 calls made by staff;
- Number of emergency room and hospital admissions;
- Number of allegations of abuse, neglect and exploitation;
- Number of confirmed allegations of abuse, neglect and exploitation;
- The number of unauthorized departures; and
- The total number of arrests of individuals by law enforcement.

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

At the time an individual is enrolled in HCS and annually thereafter, a local intellectual and developmental disability authority service coordinator must ensure that an individual or legally authorized representative is informed orally and in writing of the processes for reporting allegations of abuse, neglect, or exploitation. The toll-free number for the Department of Family and Protective Services Statewide Intake must be provided.

In addition to information provided to all individuals in the waiver, the financial management services agency provides individuals electing the consumer directed services option, and, if applicable, the designated representative, training and written information related to reporting allegations of abuse, neglect, and exploitation.

The provider agencies must ensure the continuous availability of trained and qualified employees and contractors to provide the services in an individual's individual plan of care.

The informal caregivers are unpaid natural supports and are outside the scope of waiver services. However, the individual/primary caregiver is responsible for training people who provide non-waiver natural support activities, such as informal caregivers.

Evidence supporting compliance with these requirements is reviewed during the HHSC annual certification surveys of HCS provider agencies who are serving at least one individual, contract reviews of local intellectual and developmental disability authorities, and triennial contract reviews of financial management services agencies.

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

The Department of Family and Protective Services Statewide Intake receives allegations of abuse, neglect, and exploitation of individuals enrolled in the HCS waiver program. The Department of Family and Protective Services and HHSC Provider Investigations are statutorily responsible for review, investigation, and response to those reports. HHSC Provider Investigations must complete all investigations within 30 days from the day the allegation is reported to Department of Family and Protective Services Statewide Intake.

Provider agencies enter critical incident data into the HHSC data system. HHSC also receives reports of individual deaths directly from the provider agency by the end of the next business day of the provider agency becoming aware of the death. Provider agencies will only receive the final investigative reports related to abuse, neglect, and exploitation when the alleged perpetrator is a service provider, staff member, volunteer, agent, contractors, sub-contractors, or controlling entity of the provider agency. The Department of Family and Protective Services investigates allegations of abuse, neglect, and exploitation when the alleged perpetrator is a person other than a service provider, staff member, volunteer, agent, contractors, sub-contractors or controlling entity of the provider agency.

In accordance with rules governing the operation of the HCS waiver, an individual's HCS program provider must inform the individual and the individual's local intellectual and developmental disability authority service coordinator of the findings of the investigation no later than five calendar days from the program provider's receipt of the investigation report and the corrective action taken by the program provider if it is confirmed that abuse, neglect, or exploitation occurred.

The provider agency must inform the individual and legally authorized representative of the process to appeal the investigation finding and the process for requesting a copy of the investigative report.

Additionally, the Intellectual and Developmental Disability Ombudsman (IDD Ombudsman) conducts an investigation of all complaints received, other than those for abuse, neglect, and exploitation. The HHSC IDD Ombudsman has a goal of complaint resolution and closure of the complaint case within 10 business days of receipt of the complaint. Within 10 business days of the complaint, the HHSC IDD Ombudsman their findings. Any unresolved complaints are forwarded to the appropriate department for additional follow-up.

At the time an individual is enrolled in HCS and annually thereafter, a local intellectual and developmental disability authority service coordinator and provider agency must ensure that an individual and legally authorized representative are informed orally and in writing of the processes for reporting allegations of abuse, neglect, or exploitation. The toll-free number for the Department of Family and Protective Services Statewide Intake must be provided.

The local intellectual and developmental disability authority is required to be in compliance with 40 Texas Administrative Code Chapter 4, Subchapter L (relating to Abuse, Neglect, and Exploitation in Local Authorities and Community Centers).

At the time of enrollment and at least annually thereafter, the provider agency must ensure that an individual and legally authorized representative are educated about protecting the individual from abuse, neglect, and exploitation. The provider agency must also ensure that each staff member, service provider, and volunteer are trained and knowledgeable of signs of and acts that constitute abuse, neglect, and exploitation, as well as methods to prevent abuse, neglect, and exploitation.

The financial management services agency provides individuals electing the consumer-directed services option, the individual's legally authorized representative, and, if applicable, the designated representative, training and written information related to reporting allegations of abuse, neglect, or exploitation, in addition to information provided to all individuals in the waiver.

The provider agency must ensure the continuous availability of trained and qualified employees and contractors to provide the services in an individual's individual plan of care.

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 Provider Investigations forwards completed investigation reports and findings to HHSC Long-Term Care Regulations. HHSC Long-Term Care Regulation Risk Assessment Coordinators review all investigation reports completed by Provider Investigations. Within 14 calendar days of receiving the final investigative report, the provider agency is required to notify HHSC. Based on the content of the report including recommendations from the investigator, HHSC Long-Term Care Regulation may conduct an on-site review of the provider agency or require the provider agency to submit evidence of remediation as a result of the incident. The investigative findings, HHSC LTCR follow-up activities, and provider agency remediation related to the findings are entered into the HHSC database by HHSC Long-Term Care Regulations. HHSC Long-Term Care Regulations also records deaths in the HHSC database.

Provider agencies are required to enter their critical incident data on a monthly basis. In preparation for initial certification and annual recertification surveys and some onsite visits, HHSC Long-Term Care Regulation will review the program data entry of critical incidents. HHSC has access to critical incident data through the HHSC data system and can pull reports as needed to determine provider agency compliance.

If the IDD Ombudsman is unable to resolve a complaint it is referred, along with any evidence submitted, to the appropriate area within HHSC to be reviewed.

If the complaint is referred to HHSC Long-Term Care Regulation, steps to resolve issues will be taken immediately, if necessary, or up to seven days from the time HHSC Long-Term Care Regulation receives the referral from the IDD Ombudsman. Action taken for follow-up will include a desk review of the available evidence, a request for additional evidence and/or an on-site visit to further investigate the issue. Findings related to the issues are documented in the HHSC database and shared with the IDD Ombudsman.

Oversight activities occur on an ongoing basis. Information regarding confirmed instances of abuse, neglect or exploitation are monitored, tracked, and trended for purposes of training the provider agency base to reduce the risk of recurrence.

Appendix G: Participant Safeguards

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

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

○ **The state does not permit or prohibits the use of restraints**

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

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

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

HHSC allows the use of physical restraints, chemical restraints, and mechanical restraints. HHSC prohibits the use of seclusion.

The provider agency must ensure individuals are free from unnecessary restraints during the provision of HCS Program services.

If a behavioral support plan includes techniques that involve restriction of the individual's rights or intrusive techniques, the provider agency must ensure that the plan is approved by the individual's service planning team, which includes written consent of the individual or legally authorized representative. In addition, the provider agency must:

- give verbal and written notification to the individual or legally authorized representative of the right to discontinue participation in the behavioral support plan at any time;
- assess the individual's needs and current level/severity of the behavior targeted by the plan;
- use techniques appropriate to the level/severity of the behavior targeted by the plan;
- collect and monitor behavioral data concerning the targeted behavior;
- allow for the decrease in the use of intervention techniques based on behavioral data;
- allow for revision of the behavioral support plan when the desired behavior is not displayed, or techniques are not effective; and
- consider of the effects of the techniques in relation to the individual's physical and psychological well-being.

Further, at least annually, the individual's service planning team reviews the plan to determine the plan's effectiveness and the need to continue the techniques.

The provider agency must ensure personnel report allegations of abuse, neglect, or exploitation within one hour after having knowledge or suspicion of the abuse, neglect, or exploitation to the Department of Family and Protective Services.

A provider agency is required to report critical incidents to HHSC, including aggregate restraint data. During a survey of the provider agency, HHSC reviews the critical incident data reported by a provider agency and information the provider agency has about the critical incidents reflected in the data, including information from incident reports or service records of the provider agency. HHSC may also conduct interviews of individuals, legally authorized representatives, staff, and other persons during a survey.

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 completes program provider reviews on an annual basis and in response to unresolved complaints or indications of misuse of restraints documented in the Department of Family and Protective Services and HHSC Provider Investigations investigative findings.

Deficiencies related to misuse of restraint or seclusion observed during on-site program provider reviews are entered into the HHSC Client Assignment and Registration System. Quarterly reports allow HHSC to identify trends or patterns across the provider-base as well as trends or patterns in the performance of an individual program provider agency. This information is used to guide the development of program provider training and also guide certification review staff in providing technical assistance to program provider agencies in developing systemic corrections to their operations.

Annually, HHSC reports aggregate data on critical incidents including use of restraints, serious injuries, and deaths. Program providers also enter the number of participants with a behavioral support plan. HHSC discusses any significant findings and prepares a remediation plan or improvement plan as needed.

HHSC reviews the data for trends and patterns. Improvement strategies are developed and implemented to reverse adverse trends and address patterns of concern.

Appendix G: Participant Safeguards

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

If a behavioral support plan includes techniques that involve restriction of individual rights or intrusive techniques, the provider agency must ensure that plan is approved by the individual's service planning team, which includes written consent of the individual or legally authorized representative. In addition, the provider agency must:

- Give verbal and written notification to the individual or legally authorized representative of the right to discontinue participation in the behavioral support plan at any time;
- Assess the individual's needs and current level/severity of the behavior targeted by the plan;
- Use techniques appropriate to the level/severity of the behavior targeted by the plan;
- Collect and monitor behavioral data concerning the targeted behavior;
- Allow for the decrease in the use of intervention techniques based on behavioral data;
- Allow for revision of the behavioral support plan when desired behavior is not displayed or techniques are not effective; and
- Consider of the effects of the techniques in relation to the individual's physical and psychological well-being.

Further, at least annually, the individual's service planning team reviews the plan to determine the plan's effectiveness and the need to continue the techniques.

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

Complaints concerning unnecessary/unapproved restriction of rights can be made to the local intellectual and developmental disability authority, HHSC or the Department of Family and Protective Services Statewide Intake. The local intellectual and developmental disability authority and provider agency must ensure that an individual is informed orally and in writing of the processes for filing complaints about the provision of HCS program services including:

(A) the telephone number of the local intellectual and developmental disability authority to file a complaint;

(B) the toll-free telephone number of the IDD Ombudsman to file a complaint; and

(C) the toll-free telephone number of the Department of Family and Protective Services Statewide Intake hotline to file a report of abuse, neglect, or exploitation.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

HHSC monitors improper and unauthorized use of restrictive interventions through on-site surveys (which can occur both annually or unannounced at any time). All surveys are predicated on the use of observations, interviews and record reviews to identify system or situation issues related to improper, unauthorized or over use of restrictive interventions. During a review of the provider agency, records from the provider agency and interviews with staff, individuals, individuals' families, and other service providers determine if restrictive interventions are being used without appropriate involvement of the service planning team and behavior support professionals.

HHSC follows up with all complaints and investigations and when there are concerns, HHSC requires corrective action from provider agencies. If trends are identified by the provider agency, HHSC Long-Term Care Regulation will review any action taken by the provider agency in response to the identified trends. If a trend is identified by HHSC Long-Term Care Regulation during the survey of the provider agency, HHSC may cite the provider agency for non-compliance. HHSC Long-Term Care Regulation completes quarterly trending reports of provider agencies related to abuse, neglect, and exploitation allegations. If a provider agency has greater than 5% confirmed abuse, neglect, and exploitation allegations in two quarters within a year, HHSC Long-Term Care Regulation will conduct an intermittent survey of the provider agency.

Complaints concerning the use of restrictive interventions can be made to HHSC or the Department of Family and Protective Services Statewide Intake. The provider agency must ensure that an individual is informed orally and in writing of the processes for filing complaints about the provision of HCS services including:

• The toll-free telephone number of the IDD Ombudsman to file a complaint; and
• The toll-free telephone number of the Department of Family and Protective Services Statewide Intake hotline to file a complaint of abuse, neglect, or exploitation.

Appendix G: Participant Safeguards

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

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

◉ **The state does not permit or prohibits the use of seclusion**

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

HHSC prohibits the use of seclusion in the HCS program.

Recertification surveys conducted by HHSC evaluate the provider agency's compliance with this certification principle.

While the use of seclusion is prohibited in the HCS program, it is important for provider agency personnel to know what constitutes seclusion.

Complaints concerning the use of seclusion can be made to the local intellectual and developmental disability authority, HHSC, and the Department of Family and Protective Services Statewide Intake. The local intellectual and development disability authority and provider agency must ensure that an individual is informed orally and in writing of the processes for filing complaints about the provision of HCS program services including:
(A) the telephone number of the local intellectual and developmental disability authority to file a complaint;
(B) the toll-free telephone number of the IDD Ombudsman to file a complaint; and
(C) the toll-free telephone number of the Department of Family and Protective Services Statewide Intake hotline to file a complaint of abuse, neglect, or exploitation.

○ **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.

Provider agencies must provide assistance with medication as required by the HCS certification principles located in Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D.

A nurse is responsible for the performance of health care procedures and monitoring the individual's health conditions including: the administration of medication, monitoring the individual's use of medications, and monitoring health data and information. The program provider is responsible for ensuring these tasks are performed as required by standards of professional practice and state law for licensed nursing personnel.

Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D directs that nursing services must be provided in accordance with the individual's person-directed plan; individual plan of care; implementation plan; Texas Occupations Code, Chapter 301 (Nursing Practice Act); Title 22 of the Texas Administrative Code, Chapter 217 (relating to Licensure, Peer Assistance, and Practice); Title 22 of the Texas Administrative Code, Part 11, Chapter 224 (relating to Delegation of Nursing Tasks by Registered Professional Nurses to Unlicensed Personnel for Clients with Acute Conditions or in Acute Care Environments); Title 22 of the Texas Administrative Code, Chapter 225 (relating to RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions). The Texas Administrative Code does not prescribe a particular time frame for monitoring individuals' use of medications, as the person-directed plan is individualized and the registered nurse performing the assessment determines how frequently medications as well as other health conditions should be monitored.

The implementation plan contains necessary activities for professional and non-professional staff designed to meet the individual's needs and preferences and to ensure health and safety of the individual. The program provider must routinely monitor the implementation plan to ensure that the individual's health and safety needs are being met by the program provider and to identify potentially harmful practices which may have occurred during service delivery and rectify the situation to meet the health and safety needs of the individual. Follow-up actions may include such things as personnel actions, staff training, communication with the individual's involved family members or friends who provide natural supports, or requesting a service planning team meeting to develop a solution to rectify the situation.

The use of behavior modifying medication may be monitored by a registered nurse or qualified behavioral support professional based upon the nursing or behavioral support portion of the implementation plan developed from the needs identified within the individual's person-centered plan. The registered nurse or behavioral support professional has responsibility for informing the prescribing physician of any clinical concerns regarding the individual's medication regime or presenting conditions related to medication.

HHSC Long-Term Care Regulation conducts certification reviews annually and reviews the medication error reporting of the program provider in the HHSC data system as a part of the certification review preparation. During the certification review, HHSC assesses the program provider's compliance with medication management requirements through record review, on-site observation, interviews with program provider staff, and interviews with individuals. Non-compliance with certification principles may require corrective action plans from the program provider or may result in sanction against the program provider based on the level of severity of the findings. HHSC may also refer violations of licensure to the Texas Board of Nursing.

HHSC's Quality Reporting Unit collects and analyzes performance measure data quarterly and submits completed reports to HHSC's Federal Coordination, Rules, and Committees unit for further review and analysis.

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.

Program providers must ensure that nursing is provided in accordance with:

- the individual's service plan;
- Title 3 of the Texas Occupations Code, Subtitle E, Chapter 301;
- Title 22 of the Texas Administrative Code, Part 11, Chapter 217;
- Title 22 of the Texas Administrative Code, Part 11, Chapter 224;
- Title 22 of the Texas Administrative Code, Part 11, Chapter 225; and
- Appendix C of the HCS waiver application approved by CMS and consists of performing health care activities and monitoring the individual's health conditions, including:

(A) administering medication;
(B) monitoring the individual's use of medications;
(C) monitoring health risks, data, and information, including ensuring that an unlicensed service provider is performing only those nursing tasks identified from a nursing assessment;
(D) assisting the individual to secure emergency medical services;
(E) making referrals for appropriate medical services;
(F) performing health care procedures ordered or prescribed by a physician or medical practitioner and required by standards of professional practice or law to be performed by a licensed nurse; and
(G) delegating nursing tasks to an unlicensed service provider and supervising the performance of those tasks in accordance with state law and rules;
(H) teaching an unlicensed service provider about the specific health needs of an individual;
(I) performing an assessment of an individual's health condition

HHSC Long-Term Care Regulation conducts annual on-site certification reviews of all program providers serving at least one individual. Intermittent oversight reviews are also conducted if a pattern of unresolved complaints or critical incidents is detected or if a program provider’s past performance warrants more frequent review.

HHSC may take the following actions based on outcomes of on-site program provider reviews:

Certification Survey
If HHSC Long-Term Care Regulation determines after an initial or annual survey that the program provider is in compliance with all certification principles, HHSC certifies the program provider. If HHSC Long-Term Care Regulation determines based on a review that the program provider is not in compliance with all of the certification principles, HHSC may take one or more of the following actions: request a corrective action plan; request written evidence of correction; conduct a review or onsite visit; impose a vendor hold; or deny certification.

Plan of correction
A program provider’s corrective action plan must specify the date by which corrective action will be completed for each violation. For a violation that is a condition of a serious nature, the date must be no later than 30 calendar days after the date of the review exit conference. For a violation that is not a condition of a serious nature, the date must be no later than 90 calendar days after the date of the review exit conference. If HHSC approves the corrective action plan, the program provider must complete the corrective action in accordance with the corrective action plan. If HHSC does not approve the corrective action plan, the program provider must submit a revised corrective action plan.
Verification of corrective action: HHSC may:
- request that the program provider submit written evidence of correction to HHSC; or
- conduct a review:

for a violation that is a condition of a serious nature no sooner than 31 calendar days after the review exit conference;
for a violation that is not a condition of a serious nature no sooner than 90 calendar days after the review exit conference.

Vendor Hold
If HHSC Long-Term Care Regulation implements a vendor hold against the program provider, HHSC Long-Term Care Regulation conducts a second on-site follow-up review between 30 and 45 calendar days after the effective date of the vendor hold. Based on the results of the review, HHSC Long-Term Care Regulation may certify the program provider and remove the vendor hold or may deny certification of the program provider and initiate

termination of the program provider agreement.

If HHSC determines that a hazard to the health or safety of one or more individuals exists and the hazard is not eliminated before the end of the review exit conference, HHSC denies certification of the program provider, initiates termination of the program provider's Medicaid provider agreement, implements vendor hold, and, in conjunction with the local intellectual and developmental disability authority, coordinates the transfer of the individuals receiving waiver services from the program provider to another program provider. A hazard to health or safety is any condition that could result in life-threatening harm, serious injury, or death of an individual or other person within 48 hours. If hazards are identified by HHSC during a review and the program provider corrects the hazards before the end of the review exit conference, the correction will be designated in HHSC's report of the review.

If HHSC Long-Term Care Regulation determines that a program provider's failure to comply with one or more of the certification principles is of a serious or pervasive nature, HHSC Long-Term Care Regulation may, at its discretion, take any action described above against the program provider. If HHSC Long-Term Care Regulation determines that a program provider has falsified documentation used to demonstrate compliance with the certification principles, HHSC Long-Term Care Regulation may, at its discretion, take any action described above against the program provider.

If a program provider’s certification is withdrawn, HHSC immediately notifies the appropriate local intellectual and developmental disability authorities. The local intellectual and developmental disability authorities notify the affected individuals through the service coordinators and begin transition activities for the affected individuals. If individuals’ health or safety is determined by HHSC Long-Term Care Regulation to be in jeopardy, HHSC Long-Term Care Regulation works with the appropriate local intellectual and developmental disability authorities to find temporary respite for individuals until transition to another chosen program provider can occur.

All current program provider certification results are available to individuals as posted on the Quality Reporting System webpage which is accessed through the HHSC website. HHSC Long-Term Care Regulation trends citation data for the purposes of identifying particular program providers which need technical assistance or intermittent reviews. HHSC Long-Term Care Regulation also uses trending data to identify technical assistance and training needs for statewide webinars and on-site statewide training opportunities.

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).

Program providers must provide assistance with medication as required by the HCS certification principles located in Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D and in accordance with the Texas Board of Nursing rules as defined by Title 22 of the Texas Administrative Code, Part 11, Chapter 225.

The rules also require the program provider implement and maintain a plan for initial and periodic training of staff members and service providers that ensures staff members and service providers are qualified to deliver services as required by the current needs and characteristics of the individuals to whom they deliver services.

A Registered Nurse is responsible for doing the following:

1. performing a nursing assessment for each individual before an unlicensed service provider performs a nursing task for the individual unless a physician has delegated the task as a medical act under Title 3 of the Texas Occupations Code, Subtitle B, Chapter 157, as documented by the physician and as determined necessary by a registered nurse, including if the individual's health needs change;
2. documenting information from performance of a nursing assessment and, if an individual is receiving a service through the consumer directed services option, providing a copy of the documentation to the individual's service coordinator;
3. developing the nursing service portion of an individual's implementation plan, which includes developing a plan and schedule for monitoring and supervising delegated nursing tasks; and
4. making and documenting decisions related to the delegation of a nursing task to an unlicensed service provider and ensuring that an unlicensed service provider has been trained by a registered nurse or a licensed vocational nurse under the direction of a registered nurse regarding the proper administration of medication or has been determined to be competent by a registered nurse or a licensed vocational nurse under the direction of a registered nurse regarding proper administration of medication, including through a demonstration of proper technique by the unlicensed service provider.

A registered nurse or a licensed vocational nurse under the supervision of a registered nurse reviews the administration of medication to an individual by an unlicensed service provider at least annually and after any significant change in the individual's condition.

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:

Texas Health and Human Services Commission (HHSC)

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

Program providers are required to record any type of medication error, regardless of the severity.

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

A medication error is reported when there is a discrepancy between what a physician prescribes and what an individual takes and the individual self-administers medication under supervision of the program provider or has medication administered by the program provider. A medication error occurs if the error involves the wrong medication, wrong route, the wrong dose of a medication, the wrong time or an omitted dose of a medication.

On a monthly basis program providers are required to report medication errors committed by program provider staff or occurring under the supervision of the program provider to the HHSC data system.

○ **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.

On an on-going basis HHSC is responsible for monitoring program provider compliance with the HCS certification principles located in Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D. At least annually, on-site certification reviews conducted by HHSC Long-Term Care Regulation include assessing the program provider's level of compliance with medication management and monitoring.

HHSC maintains a Long-Term Care Regulation database that records the level of compliance of all program providers per certification principle violation. The Long-Term Care Regulation database includes level of compliance information regarding medication management and monitoring.

On a monthly basis, program providers are required to report any medication errors committed by program provider staff or occurring under the supervision of the program provider that occurred during the preceding month in the automated Critical Incident Reporting System in the HHSC data system. This data is available to HHSC staff. HHSC Long-Term Care Regulation reviews the data from the Critical Incident Reporting System monthly. The data is reviewed for the purposes of identifying trends which indicate a need for an intermittent review of a program provider or technical assistance in this area of service provision as well as for the purpose of identifying statewide training needs. Depending on the frequency of occurrence or the severity of errors, HHSC may follow-up with the program provider or elect to conduct an on-site intermittent review.

Medication errors are reviewed by HHSC as a result of a certification review, annually or intermittently, or as a follow-up to a complaint from HHSC Consumer Rights and Services. During a review by HHSC of the program provider, data is obtained from the HHSC data system, the HHSC Long-Term Care Regulation database, incident reports, and service records from the program provider or interviews with individuals, staff, and other informants.

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 instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
G.a.1 Number and percent of individuals who were free from confirmed allegations of abuse. N: Number of individuals who were free from confirmed allegations of abuse. D: Number of enrolled individuals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Salesforce Abuse Neglect and Exploitation Database

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

Data Aggregation and Analysis:

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

Performance Measure:
G.a.2 Number and percent of individuals who were free from confirmed allegations of neglect. N: Number of individuals who were free from confirmed allegations of neglect. D: Number of enrolled individuals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Salesforce Abuse Neglect and Exploitation Database

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

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

Data Aggregation and Analysis:

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

Performance Measure:

G.a.3 Number and percent of individuals who were free from confirmed allegations of exploitation. N: Number of individuals who were free from confirmed allegations of exploitation. D: Number of enrolled individuals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Salesforce Abuse Neglect and Exploitation Database

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

Data Aggregation and Analysis:

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

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

Performance Measure:
G.a.4 Number and percent of surveyed contracts that include individuals with reviewed records who received information on how to report abuse, neglect, and exploitation. N: Number of surveyed contracts that include individuals with reviewed records who received information on how to report abuse, neglect, and exploitation. D: Number of surveyed contracts.

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

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

Specify:		Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Approximately 25% of active contracts are reviewed each quarter, for a 100% review of contracts per waiver year. A random sample of individual service plans are evaluated during each contract survey.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
G.a.5 Number and percent of individuals free from allegations of abuse, neglect, or exploitation. N: Number of individuals free from allegations of abuse, neglect, or exploitation. D: Number of enrolled individuals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Salesforce Abuse Neglect and Exploitation Database

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

Data Aggregation and Analysis:

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

Performance Measure:
G.a.6 Number and percent of surveyed contracts that include individuals with reviewed records who were informed of procedures for filing a complaint. N: Number of surveyed contracts that include individuals with reviewed records who were informed of procedures for filing a complaint. D: Number of surveyed contracts.

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

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Approximately 25% of active contracts are reviewed each quarter, for a 100% review of contracts per waiver year. A random sample of individual service plans are evaluated during each contract survey.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
G.a.7 Number and percent of provider-reported deaths reviewed during the required timeframe. N: Number of provider-reported deaths reviewed during the required timeframe. D: Number of provider-reported deaths.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Salesforce Abuse Neglect and Exploitation Database

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

Data Aggregation and Analysis:

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

Performance Measure:
G.a.8 Number and percent of provider-reported deaths of individuals free from previous confirmed allegations of abuse, neglect, or exploitation (ANE). N: Number of provider-reported deaths of individuals free from previous confirmed ANE within three months prior to the date of death. D: Number of provider-reported deaths received during the reporting period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Salesforce Abuse Neglect and Exploitation Database

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G.a.9 Number and percent of surveyed contracts for which providers followed HHSC policy to address abuse, neglect, or exploitation (ANE) allegations. N: Number of surveyed contracts for which providers followed HHSC policy to address abuse, neglect, or exploitation (ANE) allegations. D: Number of surveyed contracts associated with ANE allegations.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Approximately 25% of active contracts are reviewed on a quarterly basis totaling a 100% review of contracts for each annual reporting occasion.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state 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 surveyed contracts for which the provider addressed critical incidents that occurred during the reporting period. N: Number of surveyed contracts for which the provider addressed critical incidents that occurred during the reporting period. D: Number of surveyed contracts.

Data Source (Select one):
Other

If 'Other' is selected, specify:
ASPEN

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Approximately 25% of active contracts are reviewed on a quarterly basis totaling a 100% review of contracts for each annual reporting occasion.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.b.2 Number and percent of complaints addressed according to HHSC policies and procedures. N: Number of complaints addressed according to HHSC policies and procedures. D: Number of complaints.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HHS Enterprise Admin Reporting and Tracking System

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G.b.3 Number and percent of surveyed contracts not decertified for failure to address critical incidents according to program rules. N: Number of surveyed contracts not decertified for failure to address critical incidents according to program rules. D: Number of surveyed contracts.

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

Waiver Enforcement Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Approximately 25% of active contracts are reviewed on a quarterly basis totaling a 100% review of contracts for each annual reporting occasion.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.b.4 Number and percent of surveyed contracts without an administrative penalty imposed for failing to address critical incidents according to program rules. N: Number of surveyed contracts without an administrative penalty imposed for failing to address critical incidents according to program rules. D: Number of surveyed contracts.

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

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Approximately 25% of active contracts are reviewed on a quarterly basis totaling a 100% review of contracts for each annual reporting occasion.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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 surveyed contracts that were not cited for the use of unauthorized restrictive interventions. N: Number of surveyed contracts that were not cited for the use of unauthorized restrictive interventions. D: Number of surveyed contracts.

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

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

	☒ **Continuously and Ongoing**	☒ **Other** Specify: Approximately 25% of active contracts are reviewed on a quarterly basis totaling a 100% review of contracts for each annual reporting occasion.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

G.c.2 Number and percent of surveyed contracts that were not cited for the use of unauthorized restraint. N: Number of surveyed contracts that were not cited for the use of unauthorized restraint. D: Number of surveyed contracts.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Approximately 25% of active contracts are reviewed on a quarterly basis totaling a 100% review of contracts for each annual reporting occasion.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.c.3 Number and percent of surveyed contracts that were not cited for the use of seclusion. N: Number of surveyed contracts that were not cited for the use of seclusion. D: Number of surveyed contracts.

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

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

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Approximately 25% of active contracts are reviewed on a quarterly basis totaling a 100% review of contracts for each annual reporting occasion.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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 surveyed contracts that include individuals with reviewed records who received Nursing services according to state rule. N: Number of surveyed contracts that include individuals with reviewed records who received Nursing services according to state rule. D: Number of surveyed contracts.

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

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Approximately 25% of active contracts are reviewed each quarter, for a 100% review of contracts per waiver year. A random sample of individual service plans are evaluated during each contract survey.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

In accordance with state law, HHSC maintains an Employee Misconduct Registry that includes the names of persons HHSC or Texas Department of Family and Protective Services has confirmed to have abused, neglected, or exploited an individual receiving services from any of the following entities:
• licensed intermediate care facilities for individuals with intellectual disabilities or related conditions;
• nursing facilities;
• assisted living facilities;
• adult foster care facilities;
• day activity and health services facilities;
• home and community support services agencies, which include hospice and home health agencies; and
• persons exempt from licensing under Title 2 of the Health and Safety Code §142.003(a)(19), which includes HCS provider agencies.

In addition, in accordance with federal law, HHSC maintains a Nurse Aide Registry that lists certified nurse aides. The Nurse Aide Registry indicates if an aide has been confirmed to have abused, neglected, or exploited a resident of a licensed nursing facility. Provider agencies and local intellectual and developmental disability authorities must consult these registries prior to offering employment to a non-licensed service provider and refrain from employing that person if either registry indicated the person was confirmed to have abused, neglected, or exploited an individual receiving services.

Texas state law prohibits provider agencies and local intellectual and developmental disability authorities from employing a person whose criminal background indicates the person has been convicted of certain felonies.

Provider agencies and local intellectual and developmental disability authorities are required to complete pre-employment criminal background checks for each non-licensed applicant that will provide services to an individual enrolled in the HCS program.

The Quality Assurance Improvement unit of HHSC will continue its National Core Indicators In-Person project with the individuals who participate in home and community-based service programs operated by HHSC. Individuals receiving HCS are included in the sample at least every two years. As a part of the National Core Indicators In-Person surveys, individuals who receive services in the HCS waiver may respond to indicators regarding health, welfare and rights.

Some of the topics in the survey tool include protection from abuse and neglect, the ability to secure needed health services, medication management, protection of and respect for individual rights, and support to maintain health habits.

Discovery findings from the National Core Indicators In-Person survey project will be routinely evaluated to assess the status of remediation and improvement activities. In addition, HHSC will use findings to update the HCS Quality Improvement Strategy as necessary. Findings from the National Core Indicators In-Person survey will be provided to HHSC each year the survey is administered.

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.

Certification Survey
If HHSC Long-Term Care Regulation determines after an initial certification or annual recertification survey that the provider agency is in compliance with all certification principles, HHSC Long-Term Care Regulation certifies the provider agency. If HHSC Long-Term Care Regulation determines based on a survey that the provider agency is not in compliance with all of the certification principles, HHSC takes one or more of the following actions: requires a plan of correction; conducts a follow-up survey; requires evidence of correction; imposes an administrative penalty; imposes a vendor hold; or denies or terminates certification.

Plan of Correction
A provider agency must submit an acceptable plan of correction that:
- Specifies what corrective action will be taken for those individuals affected by the deficient practice;
- Explains how other individuals who have the potential to be affected by the same deficient practice will be identified;
- Identifies what measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur;
- Provides how the corrective actions will be monitored to ensure the deficient practice is being corrected and will not recur; and
- Specifies the date by which corrective action will be completed for each violation.

For a critical violation, the date must be no later than 30 calendar days after the date of the review exit conference. For a non-critical violation, the date must be no later than 45 calendar days after the date of the survey exit conference.

If HHSC approves the plan of correction, the provider agency must complete the corrective action in accordance with the plan of correction. If HHSC does not approve the plan of correction, the provider agency must submit a revised plan of correction.

Verification of Corrective Action:
If HHSC approves a plan of correction, HHSC may take the following actions to determine if a provider agency has completed corrective action:
- request that the provider agency submit evidence of correction to HHSC; or
- conduct a survey:
  - for a critical violation, after the date specified in the plan of correction for correcting the violation but within 45 days after the survey exit conference, unless the provider agency requests HHSC conducts an earlier follow-up survey as allowed in state rule;
  - for a non-critical violation, at least 46 days after the survey exit conference unless the provider agency requests HHSC conducts an earlier follow-up survey as allowed in state rules.

Administrative Penalties
HHSC may impose and collect an administrative penalty against a HCS provider agency for a violation of a certification principle contained in the Texas Administrative Code pertaining to the HCS program. HHSC may also impose and collect an administrative penalty against a HCS provider agency for any of the following actions: willfully interfering with the work of a representative of HHSC, which may include making a false statement of a material fact the provider agency knows or should know is false with respect to a matter under investigation by HHSC; or failing to pay an administrative penalty within 10 calendar days after the date the assessment of the penalty becomes final.

Vendor Hold
If HHSC implements a vendor hold against the HCS provider agency, HHSC conducts a second on-site follow-up review between 30 and 45 calendar days after the effective date of the vendor hold. Based on the results of the review, HHSC may certify the HCS provider agency and recommend the removal of the vendor hold or may recommend further contract actions such as denial or termination of certification of the HCS provider agency. HHSC may then initiate termination of the provider agency agreement.

Administrative Penalty and Vendor Hold
If HHSC imposes an administrative penalty against a provider agency for a violation or action, HHSC does not, at the same time, impose a vendor hold or otherwise withhold contract payments from the provider agency for the

same violation or action.

HHSC conducts at least annually, unannounced surveys of each residence in which residential support or supervised living is provided to verify that the residence provides an environment that is healthy and safe for the individuals who live there and complies with the HHSC rules. HHSC may, at any time, conduct any unannounced survey of a residence in which host home/companion care, is provided to determine if the residence provides an environment that is healthy and safe for the individuals who live there and complies with HHSC rules.

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

Due to the character limit in G-Quality Improvement-b.i, the response to G-Quality Improvement-b.i continues in the 'Main: B. Optional' section.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 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.

The Quality Improvement Strategy utilizes numerous quality indicators that are tracked and reported on a quarterly basis. HCS system data are aggregated, monitored, and analyzed on no less than an annual basis. HHSC analyzes trends and identifies and prioritizes areas for improvement. These findings are reported to the Quality Review Team.

The Quality Review Team, which consists of representatives from several departments within HHSC, reviews HCS data to establish priorities and directs improvement activities for the waiver. The Quality Review Team oversees implementation of the quality improvement strategy and related processes. This includes making recommendations for new or revised quality measures, identifying and facilitating access to new data sources, identifying new intra- and interagency processes impacting all phases of the quality program, and other actions needed to assure continued improvement of the HCS waiver program.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The Quality Review Team meets quarterly and reviews comprehensive quality reports from each waiver at least annually. These quarterly and annual reports include data for all of the waivers' 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 and approves all improvement plans, modifying if needed. All active improvement plans for all waivers are monitored at each Quality Review Team meeting. This includes updates to determine whether improvement activities have had the intended effect.

Stakeholders have the opportunity to provide testimony on policies and rules governing the delivery of services in the HCS waiver in writing and at meetings of the Medical Care Advisory Committee and the HHSC Executive Council. Stakeholders may also provide feedback and comments anytime to the HCS email box.

The Intellectual and Developmental Disability System Redesign Advisory Committee, created by Texas Government Code Chapter 534, advises HHSC on the implementation of the acute care services and long-term services and supports system redesign for people with intellectual and developmental disabilities. The Intellectual and Developmental Disability System Redesign Advisory Committee is comprised of external stakeholders from the intellectual and developmental disabilities communities. The Intellectual and Developmental Disability System Redesign Advisory Committee collaborates with HHSC by providing recommendations and identifying areas for improvement. The committee consists of 26 members representing communities of interest as identified in Texas Government Code, Section 534.053. The Intellectual and Developmental Disability System Redesign Advisory Committee and subcommittees meet quarterly.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

HHSC will evaluate the Quality Improvement Strategy at least every three years. HHSC staff will evaluate the processes and indicators of the Quality Improvement Strategy. HHSC will examine issues such as whether the indicators are providing substantive information about each sub-assurance; 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, HHSC 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):*

Texas deployed the NCI Adult Consumer Survey now known as the In-Person Survey, in 2019, as well as the NCI Child Family Survey in 2018. The surveys are organized across five general topics – health and welfare, choice and respect, community inclusion, systems performance, and services satisfaction.

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).*

Provider agencies and financial management services agencies are not required to be independently audited. HHSC uses a fiscal monitoring process, provider fiscal compliance reviews, to ensure that HCS provider agencies and financial management services agencies are complying with waiver requirements. HHSC conducts fiscal monitoring of HCS provider agencies on-site at least every four years and typically reviews a three month sample of the provider agency's records, but may lengthen that sample period if deemed necessary. Financial management services agencies are monitored at a minimum of every three years. Typically, a six-month sample of financial management services agencies' records are reviewed.

The methods used in the monitoring process include:
• Review of the provider agency's or financial management services agency's existing billing system and internal controls;
• Comparison of the provider agency's or financial management services agency's service delivery records with its billing records to verify that payments HHSC made to the provider agency or financial management services agency were appropriate;
• Review of service plans and records; and
• Comparison of service delivery and other supporting documentation with service plans.

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

HHSC may perform desk and on-site compliance reviews associated with claims the provider agency or financial management services agency submits under a provider agreement. HHSC recovers improper payments, without extrapolation, if HHSC verifies that the provider agency or financial management services agency has been overpaid because of improper billing or accounting practices or failure to comply with the provider agreement.

The provider agency or financial management services agency must provide the documentation HHSC requests to support the provider agency's or financial management services agency's submitted claims. If the provider agency or financial management services agency fails to provide the requested information, HHSC may take adverse action against the provider agreement.

HHSC may withhold payments and apply them to the payments provider agency owes HHSC. Corrective action may be required for findings based upon the provider fiscal compliance review of the provider agency, or the program and fiscal compliance monitoring reviews of the financial management services agency.

Provider agencies are subject to intermittent audits following complaints concerning fiscal compliance. Provider agencies submit biennial cost reports to HHSC Provider Finance Department, as required, which are subject to audit by HHSC's Cost Report Review Unit.

The specified frequency for monitoring FMSAs at least every three years and HCS service providers for provider fiscal compliance reviews every four years was determined to be sufficient for effectively identifying unsatisfactory contract performance issues and promoting accountability, without unnecessarily increasing costs. The current processes, procedures, and robust tools focus on items that are most important and assist staff with identifying problem areas. Service providers with ongoing noncompliance are referred for increasing remediation up to and including contract termination.

In addition, provider fiscal compliance review staff and FMSA monitoring staff can and do initiate compliant investigations/reviews based on referrals.

There are situations in which Long-Term Care Regulation identifies performance or accountability issues during annual reviews that are relative to Billing and Payment, and in such situations a referral for follow up is made. The State's Billing and Payment department and the Long-Term Care Regulation department both verify services delivered are approved by the Person Directed Plan and the Individual Plan of Care.

The Texas State Auditor's Office is responsible for the annual statewide financial and compliance audit. The Office of the Inspector General is responsible for performing audits of provider agreements between HHSC and service providers.

For provider fiscal compliance reviews, the sample used for these reviews is a balance between a representative sample and a stratified sample. This balance is achieved by ensuring the sample is representative of the services provided to individuals within the contract, but also targeted to areas of known service issues or past noncompliance for a service provider. Billing and Payment staff determines the three month timeframe by reviewing the past 24 months of billing,

identifying time periods impacted by program or guideline changes, ensures that an adequate and representative (as it relates to the 24 months) claim record is reflected in a three month period, and, if the other criteria are satisfied, selects a period over 12 months prior to entrance date to prevent alteration of the claim record. If the other criteria are not satisfied for time periods between 24 months and 12 months prior to the entrance B&P may select a time period within 12 months of the entrance.

During a provider fiscal compliance review, the State reviews all service delivery records during the sample timeframe to ensure HCS services are provided in accordance with State approved billing guidelines.

To comply with §1903(l) of the Social Security Act, as added by the 21st Century Cures Act, HHSC requires HCS provider agencies and financial management service agency's (FMSA's) to use electronic visit verification (EVV) for in-home respite, and in-home individualized skills and socialization. As described in 1903(l)(4)(B) of the Social Security Act, Texas has received an extension to the expansion of EVV to home health services, and will expand EVV to include nursing, physical therapy, and occupational therapy effective January 1, 2024.

HHSC EVV Operations conducts EVV compliance reviews to ensure program providers and FMSA's are in compliance with EVV requirements and policies. Provider agencies and FMSAs who fail to comply with EVV requirements and policies may be subject to enforcement actions.

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 Total dollar amount and percent of total dollar amount of reviewed claims that were coded and paid for according to the reimbursement methodology specified in the approved waiver. N: Total dollar amount of reviewed claims that were coded and paid for according to the reimbursement methodology specified in the approved waiver. D: Total dollar amount of reviewed claims.

Data Source *(Select one):*
Other

If 'Other' is selected, specify:
Provider Fiscal Compliance Database

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☒ ***Other*** *Specify:* *Sample size is based upon prior error rate, total contract census, and whether a routine review was conducted. Samples consist of 5-10 individuals plus 5-10% of individuals provided services.*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

Performance Measure:
I.a.2 Number and percent of paid claims that reflect only the services listed in the service plan. N: Number of paid claims that reflect only the services listed in the service plan. D: Number of paid claims.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Quality Assurance and Improvement Data Mart

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

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

Data Aggregation and Analysis:

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

Performance Measure:
I.a.3 Number and percent of reviewed provider agencies not requiring a corrective action plan evidenced by an overall fiscal compliance score of at least 90%. N: Number of reviewed provider agencies not requiring a corrective action plan evidenced by an overall fiscal compliance score of at least 90%. D: Number of reviewed provider agencies.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Provider Fiscal Compliance database

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☒ ***Other*** *Specify:* *Reviews are conducted cyclically in order based on oldest review and staff availability. Provider agencies are reviewed for fiscal compliance at least once every four years in the HCS waiver.*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
I.b.1 Number and percent of provider payment rates that are consistent with the rate methodology in the approved waiver. N: Number of provider payment rates that are 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 Provider Finance 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 =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

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.*

HCS provider agencies and financial management services agencies enter billing claims into the HHSC data system, which assigns the correct reimbursement rate associated with the billing code entered by a provider agency/financial management services agency. The HHSC data system automatically rejects any claim that is entered with an unauthorized billing code or for a service not included in an individual's authorized service plan. A report on this assurance is prepared annually and reviewed by the Quality Review Team.

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 HHSC detects provider agency non-compliance with the program billing requirements, HHSC requires the provider agency to implement corrective action. Following a provider fiscal compliance reviews all provider agencies receive a written review report that details the specific areas of non-compliance found during the review and includes instruction regarding the provider agency's responsibility with regard to the areas of deficiency. HHSC then conducts follow-up activities in accordance with HCS provider agency review procedures and financial management services agency review procedures to ensure corrective action has been implemented. HHSC recoups funds when claims for services to individuals were found in error.

HHSC has the responsibility of executing provider agreements, including day-to-day operations, of Financial Management Services and monitoring of financial management services agencies. HHSC financial management services agency monitoring staff monitors 100 percent of financial management services agencies at a minimum of every three years. These reviews are conducted via desk review or at the location where the financial management services agency is providing financial management services. HHSC assesses a financial management services agency's performance by:

1. *Measuring adherence to rules in Title 40 of the Texas Administrative Code, Part 1, Chapters 41 and 49;*
2. *Matching payroll, optional benefits, and tax deposits to time-sheets;*
3. *Ensuring that the hours worked, and the rate of pay are consistent with individual budgets;*
4. *Reviewing administrative payments; and*
5. *Reviewing the service provider agreements.*

HHSC recovers improper payments, without extrapolation, and verifies that the provider agency or financial management services agency has been overpaid because of improper billing or accounting practices or failure to comply with the provider agreement terms. HHSC staff prepares a written report itemizing claims found in error during each review. A summary of each review, including the name of the financial management services agency, the dollar amount to be subtracted from pending or future payments to the financial management services agency, if applicable, and any follow-up action to be taken is scanned and sent electronically on a monthly basis. HHSC staff enters the monitoring information into the Health and Human Services Contract Administration and Tracking System. HHSC staff uses the data entered into this system to track monitoring and billing disallowances.

HHSC staff conducts intermittent monitoring reviews to ensure that the financial management services agency has taken the necessary steps to attain and maintain compliance at the required performance level. HHSC staff recommends further action or possible sanctions if the financial management services agency remains out of compliance.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

HHSC, the single State Medicaid Agency, determines payment rates every two years, coinciding with HHSC's legislative biennium. Payment rates are determined for each service. The rates for services are prospective and uniform statewide. HHSC reimburses provider agencies for contracted client services through reimbursement amounts determined as described in Title 1 of the Texas Administrative Code, Part 15, Chapter 355, and in reimbursement methodologies for each program. 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. Statewide, uniform reimbursements and reimbursement ceilings are approved by HHSC. Methodology rules are developed and adopted by HHSC. The rates for the HCS waiver are available on the HHSC Provider Finance Department webpage.

In order to ensure adequate financial and statistical information upon which to base reimbursement, HHSC requires each contracted provider agency to submit a periodic cost report or supplemental report. Provider agencies are responsible for eliminating all unallowable expenses from the cost report prior to submission of the cost report. The cost report contains information on direct service costs, including direct service wages, benefits, contracted services; staffing information; facility costs; operations costs; and administrations costs of the service providers. HHSC conducts a desk review of all cost reports. HHSC removes any unallowable costs and corrects any errors detected on the cost report in the course of the review. Reviewed cost reports are used in the determination of statewide prospective rates.

For general inflation adjustments, HHSC uses the Personal Consumption Expenditures (PCE) chain-type price index published by the Bureau of Economic Analysis of the U.S. Department of Commerce. HHSC uses a PCE forecast published by IHS Markit or its successor.

HHSC uses specific indices in place of the general inflation index when appropriate item- or program specific inflation indices are available from cost reports or other surveys, other Texas state agencies, nationally recognized public agencies, or independent private firms, and HHSC has determined that these specific inflation indices are derived from information that adequately represents the program(s) or cost(s) to which the specific index is to be applied.

For inflation adjustments of costs pertaining to nursing wages and salaries, HHSC uses an employment cost index of wages and salaries for private industry workers in nursing and residential care facilities published by the U.S. Bureau of Labor Statistics. HHSC uses a forecast of this inflation index published by IHS Markit or its successor. Periodic reviews of the chosen inflation index will be performed based on cumulative cost report data on nursing wages and salaries.

Costs reported on the cost reports are projected to the applicable rate period. HHSC determines reasonable methods for projecting each service provider's costs to allow for significant changes in cost-related conditions anticipated as occurring between the historical cost reporting period and the prospective rate period.

HHSC uses the projected costs from the latest, desk-reviewed cost reports to rebase modeled rates for the following services: individualized skills and socialization, respite, supported employment, host home/companion care, supervised living, residential support services, and supported home living. The initial model-based rates for these services were determined using cost, financial, statistical and operational information collected during site visits performed by an independent consultant. The data was collected from cost reports and the service providers' accounting systems. Additionally, the state fiscal year (SFY) 1996 state wage data, the SFY 1994 cost data and the SFY 1995 data from service providers was reviewed and analyzed. The base model rate year was calendar year 1997. Data from SFY 1994-1996 were used to develop the current rate structure; rates are rebased every biennium from the most recent projected cost report data, within available appropriations. Current rates are based on cost report data from service providers' most recently desk-reviewed cost reports limited to available appropriations.

HHSC uses projected cost from the 2020 cost report and modeled staffing ratios to calculate the initial modeled rates for individualized skills and socialization services.

The initial model-based rate for individualized skills and socialization uses day habilitation services costs from the most recently examined Medicaid cost report, adjusted from daily to hourly to calculate a weighted median cost. Weighted median staff costs are adjusted for anticipated staffing ratios for on-site and off-site services for each level of need and inflated from the cost reporting year to the prospective rate year. The initial model-based rates include a transportation component calculated using the most recent Day Activity and Health Services (DAHS) driver and transportation costs, including vehicle depreciation, fuel and maintenance. Once cost report data for individualized skills and socialization services is available, rates will be set based on a weighted median methodology using the most recently examined cost

report. The individualized skills and socialization rates are rebased every biennium from the most recent projected cost report data, within available appropriations.

Nursing, speech and language pathology, occupational therapy, physical therapy, dietary, and behavioral support services are provided under more than one Home and Community-based 1915(c) waiver. The rates for these services are determined by combining the allowable costs per unit of service for the service providers with provider agreements in all the waivers offering these services into an array. The array is weighted by the number of units of service and the median cost per unit of service is calculated.

Prescribed drugs are paid at cost.

When historical costs are unavailable, such as in the case of changes in program requirements, payment rates may be based on a pro forma approach. This approach involves using historical costs of delivering similar services, where appropriate data are available, and estimating the basic types and costs of products and services necessary to deliver services meeting federal and state requirements. Data sources may include: cost report data; state and national salary data; administrative costs of providers and staff who will deliver the service; and other data applicable to the service or specific industry. HHSC models rates as specified below.

The reimbursement for transition assistance services is modeled using this pro forma approach utilizing costs for similar services with similar staff requirements.

The reimbursement for audiology and social work is modeled using this pro forma approach utilizing reputable external data sources, including Bureau of Labor Statistics wage data for similar staff requirements.

Minor home modifications, adaptive aids, and dental treatment services are paid at cost. Service providers are given additional payments for the cost of acquiring minor home modifications, adaptive aids, and dental treatment services for individuals; these payments are called requisition fees. The rates for the requisition fees are determined by modeling the estimated time required for staff to conduct the assessment of the need for the service, purchase the item, and complete any necessary follow-up.

In setting the rates for financial management services provided under the consumer directed services option, the reimbursement rate to the financial management services provider is a flat monthly fee, determined using provider cost data, collected on a periodic basis. The FMSA monthly rate equals a weighted average of allowable FMSA costs, adjusted from the cost reporting year to the prospective rate year. The payment rate available for the individual's budget for the self-directed service is modeled on the payment rate to the traditional agency less an adjustment for the traditional agency's indirect costs.

The financial management services agency is responsible for providing rate information to the consumer-directed services option employer. For individuals not in the consumer-directed services option, the document created during the service planning team meeting, the individual plan of care, contains the rates for each service. This form is reviewed and signed by the individual and/or legally authorized representative.

HHSC publishes notice of proposed adjustments at the earliest feasible date but not later than ten state working days before the effective date of the adjustment in the Texas Register. HHSC holds a public hearing before it approves rates to allow interested persons to present comments relating to the proposed rates, and HHSC provides notice of the hearing to the public. The notice of the public hearing includes the location, date, and time for the hearing and 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 HHSC websites as well as through the Texas Register via a public notice.

The rate for support consultation is modeled using this pro forma approach utilizing reputable external data sources, including Bureau of Labor Statistics wage data for similar staff requirements. Wage costs are inflated to the prospective rate period.

Provider agencies of: day habilitation, respite, supported employment, supervised living/residential support services, and

supported home living have the option of participating in the attendant compensation rate enhancement program. Individualized skills and socialization providers have the option of participating in the attendant compensation rate enhancement program beginning in State Fiscal Year 2024.

HHSC adopted rules in Title 1 of the Texas Administrative Code, Part 15, Chapter 355, Subchapter A to establish procedures for community care providers to obtain additional funds for increased attendant wages, benefits/insurance, and mileage reimbursement. Community Care provider agencies who choose to participate in the attendant compensation rate enhancement program and receive additional funds must demonstrate compliance with enhanced spending requirements. For provider agencies who choose not to participate in the attendant compensation enhancement program, the attendant compensation rate is calculated as a weighted median attendant compensation cost for each attendant service, using the most recently examined cost report limited to available appropriations.

Participation in the attendant compensation rate enhancement program is voluntary. Enrollment in Attendant Compensation Enhancement Rate program is held in July prior to the rate year. Provider agencies may choose to participate in attendant compensation rate enhancement program by submitting to HHSC an electronic Enrollment Contract Amendment choosing to enroll and indicating the level of enhanced add-on rate they desire to receive. Requested add-on rate levels are granted beginning with the lowest level and granting successive levels until requested enhancements are granted within available funds.

Due to the character limit in I-2-a, the response to I-2-a continues in the 'Main: B. Optional' section.

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:*

HCS provider agencies and financial management services agencies enter individual service usage information (billing claims) into the HHSC electronic billing system. HCS provider agencies and financial management services agencies submit appropriate receipts for Adaptive Aids, Minor Home Modifications, and Dental Treatment that are authorized for payment by HHSC staff. Following authorization, the program providers and financial management services agencies submit electronic claims for the Adaptive Aids, Minor Home Modifications, or Dental Treatment.

Whether delivered through the traditional agency option or the consumer directed services option, provider agencies and financial management services agency electronically submit claims for reimbursement for waiver services that were provided to individuals to the CMS-approved State Medicaid Management Information System.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

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

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

HCS provider agencies and financial management services agencies may enter electronic billing claims weekly. A claim includes the total units of each service delivered to an individual, the date of delivery, and the amount due the provider agency or financial management services agency. HHSC's electronic billing system verifies the following before a billing claim is approved:

The individual meets level of care and financial eligibility requirements on the date of service;
The services billed are included on the individual's current, approved service plan;
The number of units and unit costs do not exceed the most current, approved service plan; and
The billing claim is complete, accurate, and is received by HHSC no later than 12 months after the last day of the month in which the service was provided.

HCS provider agencies and financial management services agencies submit appropriate receipts for adaptive aids, minor home modifications, and dental treatment that are authorized for payment by HHSC staff. Following authorization, the provider agencies and financial management services agencies submit electronic claims for the adaptive aids, minor home modifications, or dental treatment.

HHSC uses a fiscal monitoring process to ensure that reimbursement to HCS provider agencies and financial management services agencies are for services actually provided in compliance with waiver requirements. The methods used in the fiscal monitoring process and outcomes of the process are described in Appendix I-1.

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

HHSC B&P submits the unverified claims to our Provider Claims unit which will negative bill Claim for Claim in the ID Care system. This results in the next vendor payment being reduced by the recouped amount.

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:

Although the current system is not an approved MMIS, it meets the MMIS functional criteria for claims adjudication. Paid claims data is sent to the Texas Medicaid and Healthcare Partnership for each adjudication cycle.

A process is run weekly which compares received claims to the criteria for approval of claims and produces a list of adjudicated/approved claims to be processed for payment. Rate tables and service authorizations support the computation of the amount to pay and approved-to-pay claims are exported weekly to the HCS Provider Payment System. The HCS Provider Payment System computes the federal and general revenue funding split for each approved-to-pay claim, determines the accounting coding block, and builds interface transactions to the agency's accounts payable system, the Health and Human Services Accounting System. The Health and Human Services Accounting System prepares a warrant request that is sent to the Comptroller of Public Accounts who, in turn, produces a warrant that is sent to the provider agency or financial management services agency. The data used for the claims and expenditures on the CMS 64 is the adjudicated claim information contained in the Health and Human Services Accounting System. HHSC, the provider agency, the financial management services agency, and the individual employer in the consumer directed services option maintain supporting documentation to provide an audit trail.

HHSC retains copies of provider agreements between HHSC and each provider agency and financial management services agency, along with documentation of each provider agency's and financial management services agency's compliance with state standards for participation.

The State maintains the following documentation related to each individual:
• Approved service plans;
• Documentation of the individual's financial eligibility and level of care eligibility;
• A record for each individual that documents the content of service plans and details of all services approved or rejected for payment including the number of service units delivered, the date of service delivery, the amount claimed for reimbursement, copies of receipts for adaptive aids, minor home modifications and dental services, and the amount approved for reimbursement; and
• Records of terminations of individuals from waiver services.

Provider agencies, financial management services agencies, and individual employers must maintain separate service information for each individual receiving services from the provider agency. At a minimum, service documentation information includes the following: results of individual assessments, evaluations, and accompanying recommendations that identify specific needs to be addressed by the services included on the individual's service plan; service plans and revisions to plans for each individual; person-directed plan for each individual; copies of billings and vouchers submitted for reimbursement; service delivery logs indicating date and type of service provided and name of service provider; narrative documentation of outcomes of each service delivery event; verification by HHSC of the date of the individual's eligibility for enrollment and of provider agency eligibility for payment and, when applicable, records of individual's discharge from waiver services; when applicable, documentation verifying the individual's eligibility for employment assistance or supported employment; when applicable, receipts for the provision of adaptive aids, minor home modifications, and dental treatment and documentation that the provision of dental treatment, adaptive aids, or minor home modifications is authorized by the recipient's service planning team; and evidence that all service providers meet the minimum service provider qualifications at the time services were delivered.

HHSC employs a complex system of integrated accounting systems to process vendor and client payments. While all voucher processing occurs within the Centralized Accounting Payroll/Personnel System (CAPPS), vouchers can originate from external interfaces or through direct entry into the CAPPS system. Once the vouchers are posted, the CAPPS system interfaces these vouchers to the Texas Comptroller's Uniform Statewide Administrative System (USAS) for payment. Based on the vendor setup, these payments are processed through the Texas State Treasury as direct deposit (electronic funds transfers) or paper warrant. Paper warrants are returned to the agency on a daily basis for distribution to the vendor/clients.

○ ***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:

HHSC contacts with local community centers, established in accordance with Chapter 534 of the Texas Health and Safety Code, and a local Council of Government, established in accordance with Chapter 391 of the Texas Local Government Code, which have all been designated by HHSC as local intellectual and developmental disability authorities.

Local intellectual and developmental disability authorities contract as HCS provider agencies, and must provide all HCS services and receive payment for services provided. Local intellectual and developmental disability authorities may also contract to provide financial management services and support consultation under the consumer directed services option.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***

○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

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:

The non-federal share of HCS funds are appropriated by the Texas State Legislature to HHSC for the HCS program. The non-federal share is exclusively from state general revenue appropriations.

There are no Inter-Governmental Transfers (IGTs) or Certified Public Expenditures (CPEs).
- *There are no local sources of funds*
- *There are no certified public expenditures*
- *HCS non-federal share funds are appropriated to HHSC as a specific line item for the provision of the HCS waiver.*
- *If another agency was designated to operate the HCS program, those funds would be removed from HHSC and appropriated to that agency.*

HHSC HCS appropriation remains in the State Comptroller's account designated for the HCS waiver. Once the Medicaid agency has approved a claim via the Health and Human Services Accounting System federal funds are drawn and combined with the state appropriations to make payments to the provider agency.

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- ◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ○ ***The following source(s) are used***

  Check each that applies:

  - ☐ ***Health care-related taxes or fees***
  - ☐ ***Provider-related donations***
  - ☐ ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

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

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

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Payment of the cost for room and board is the responsibility of the individual except when room and board is provided under the waiver as part of out-of-home respite.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to

the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

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

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

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

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	44369.71	13953.29	58323.00	163509.45	4676.70	168186.15	109863.15
2	45701.50	14377.47	60078.97	168479.45	4819.50	173298.95	113219.98
3	47026.42	14794.42	61820.84	173364.25	4958.73	178322.98	116502.14
4	48342.63	15214.58	63557.21	178288.10	5097.96	183386.06	119828.85
5	49697.62	15646.68	65344.30	183350.40	5244.33	188594.73	123250.43

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	29819	29819
Year 2	29819	29819
Year 3	29819	29819
Year 4	29819	29819
Year 5	29819	29819

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 Average Length of Stay (ALOS) estimate of this waiver renewal (FY2024 - FY2028) assumes a point-in-time enrollment of 29,234 For WY 1 through WY 5. The monthly attrition rate assumed for all waiver years is 0.2% based on YTD WY 2022 experience through June 2022. Attrition assumes 720 individuals in each waiver year are replaced with new participants. The state estimates a carryover of 29,230 individuals from August 2023.

ALOS in months is obtained by dividing the sum of the estimated served recipient months by the unduplicated participant count (Factor C). A factor of 30.416 days was applied to the ALOS in months (11.65) for the ALOS in days. Resulting average length of stay is estimated to be 355 days for WY 1 through WY 5.

The State used the phase-in/phase-out schedule to calculate the Factor C as well as the PIT. In this instance, the term "phase-in/phase-out" is a budgetary management tool only and not the same as the terms described in the CMS Technical Guide.

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:*

The estimates for Factor D are based on utilization, units of service per user, and cost per unit information from claims payment data, CMS-372(S) report for WY 2021 (9/1/2020 - 8/31/2021) and latest established rates as of WY 2022. For ISS services, WY 23 rates were used. For services without utilization information in WY 2021, estimates were derived from a similar service or previous WYs with utilization. The service specific baseline information was then adjusted for inflation in services where no unit rate is established. Historically the state used services-specific cost growth methodology to develop cost estimates.

The estimates for factor D include a replacement benefit for Day Hab services called Individualized Skills and Socialization (ISS) with an assumed implementation date of March 1, 2023. ISS utilization is assumed to remain at current Day Hab utilization levels but at the fee schedule rates for the new ISS benefit

(1) For services where a unit rate is established:
FY22/23 rates are used for average cost per unit beginning in WY 2023 and then inflated each year by an inflation index of 3.5% for WY 2024, 3.0% for WY 2025, 2.9% for WY 2026, 2.8% for WY 2027, and 2.8% for WY 2028 was used. The inflation index used is "Health Care" price deflators (IHS Global Insight Short Term Forecast for the U.S. Economy, October 2022).

(2) For services not involving unit rates (Adaptive Aids, Dental, Minor Home Modifications, and Transition Assistance Services):
The inflation index used is "Health Care" price deflators (IHS Global Insight Short Term Forecast for the U.S. Economy, October 2022). An inflation of 3.5% for WY 2024, 3.0% for WY 2025, 2.9% for WY 2026, 2.8% for WY 2027, and 2.8% for WY 2028 was used.

(3) For prescribed drugs, the baseline WY 2021 cost per prescription ($51.35) was calculated using expenditures from the 372 report ($382,723.42) and number of prescriptions from claims data for utilization (7,453). The inflation index used is "Health Care" price deflators (IHS Global Insight Short Term Forecast for the U.S. Economy, October 2022). An inflation of 3.5% for WY 2024, 3.0% for WY 2025, 2.6% for WY 2026, 2.8% for WY 2027, and 2.6% for WY 2028 was used.

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

The baseline estimate for D' is based on the WY 2021 CMS-372(S) report. The state estimated the baseline D' cost per day using D' and ALOS information from WY 2021 CMS-372(S) and assumed inflation index for calculation of D' cost per day. Factor D' was derived from the multiplication of D' cost per day and ALOS for the waiver population of the specified WY. The estimates were adjusted for inflation. The inflation index used is "Health Care" price deflators (IHS Global Insight Short Term Forecast for the U.S. Economy, October 2022). An inflation of 3.5% for WY 2024, 3.0% for WY 2025, 2.9% for WY 2026, 2.8% for WY 2027, and 2.8% for WY 2028 was used.

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

The Factor G estimates were based on FY 2022 actual experience data. The claims data originated in the Texas Medicaid Healthcare Partnership (TMHP) Long Term Services and Supports (LTSS) Claims Management System (CMS). The state estimated the baseline G cost per patient day and trended the figure by "Health Care" price deflators (IHS Global Insight Short Term Forecast for the U.S. Economy, October 2022) of 3.5% for WY 2024, 3.0% for WY 2025, 2.9% for WY 2026, 2.8% for WY 2027, and 2.8% for WY 2028. Factor G was derived from the multiplication of G cost per patient day and ALOS for the waiver population of the specified WY.

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

The Factor G' estimates were based on FY 2022 actual experience data using both fee for service or encounters for acute care services. The state estimated the baseline G' cost per patient day and trended the figure using "Health Care" price deflators (IHS Global Insight Short Term Forecast for the U.S. Economy, October 2022) of 3.5% for WY 2024, 3.0% for WY 2025, 2.9% for WY 2026, 2.8% for WY 2027, and 2.8% for WY 2028. Factor G' was derived from the multiplication of G' cost per patient day and ALOS for the waiver population of the specified WY.

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	
Individualized Skills and Socialization	
Respite	
Supported Employment	
Adaptive Aids	
Audiology	
Occupational Therapy	
Physical Therapy	
Prescribed Drugs	
Speech and Language Pathology	
Financial Management Services	
Support Consultation	
Behavioral Support	
Cognitive Rehabilitation Therapy	
Dental Treatment	
Dietary Services	
Employment Assistance	
Minor Home Modifications	
Nursing	
Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services)	
Social Work	
Supported Home Living	
Transition Assistance 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
Individualized Skills and Socialization Total:						**220106524.25**
Individualized Skills and Socialization, Intermittent	per day	4347	195.13	46.78	**39680204.55**	
Individualized Skills and Socialization, Limited	per day	4400	417.84	50.99	**93744911.04**	
Individualized Skills and Socialization, Pervasive	per day	9756	35.30	71.13	**24496233.08**	
Individualized Skills and Socialization, Extensive	per day	1839	435.60	71.13	**56979995.29**	
Individualized Skills and Socialization, Pervasive Plus	per day	162	207.63	154.75	**5205180.28**	
Respite Total:						**5625136.91**
Provider-managed	per hour	777	173.50	19.55	**2635525.72**	
CDS	per hour	931	173.39	18.52	**2989611.19**	
Supported Employment Total:						**1139701.64**
CDS	per hour	15	250.85	33.22	**124998.56**	
Provider-managed	per hour	332	89.21	34.26	**1014703.09**	
Adaptive Aids Total:						**4474843.06**
Adaptive Aids	per hour	6165	5.58	130.08	**4474843.06**	
Audiology Total:						**14135.67**
Audiology	per hour	3	86.33	54.58	**14135.67**	
Occupational Therapy Total:						**1590256.50**
Occupational Therapy	per hour	714	29.50	75.50	**1590256.50**	
Physical Therapy Total:						**2355524.57**
Physical Therapy	per hour	874	33.63	80.14	**2355524.57**	
Prescribed Drugs Total:						**460366.68**
Prescribed Drugs					**460366.68**	

GRAND TOTAL:	**1323060281.40**
Total Estimated Unduplicated Participants:	**29819**
Factor D (Divide total by number of participants):	**44369.71**
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	per prescription	1018	7.98	56.67		
Speech and Language Pathology Total:						**5199610.75**
Speech and Language Pathology	per hour	1530	43.04	78.96	**5199610.75**	
Financial Management Services Total:						**2982798.23**
Financial Management Services	per month	1341	10.23	217.43	**2982798.23**	
Support Consultation Total:						**52.03**
Support Consultation	per hour	3	1.09	15.91	**52.03**	
Behavioral Support Total:						**11013080.47**
Behavioral Support	per hour	6851	19.53	82.31	**11013080.47**	
Cognitive Rehabilitation Therapy Total:						**53412.28**
Provider-managed	per hour	5	122.46	82.31	**50398.41**	
CDS	per hour	1	37.08	81.28	**3013.86**	
Dental Treatment Total:						**17729061.81**
Dental Treatment	per visit	16581	1.98	540.02	**17729061.81**	
Dietary Services Total:						**237611.44**
Dietary Services	per hour	1251	3.32	57.21	**237611.44**	
Employment Assistance Total:						**1440944.93**
CDS	per hour	5	140.83	33.22	**23391.86**	
Provider-managed	per hour	249	166.17	34.26	**1417553.07**	
Minor Home Modifications Total:						**898022.32**
Minor Home Modifications	per item	148	1.14	5322.56	**898022.32**	
Nursing Total:						**26147036.87**
CDS	per hour	16	712.02	43.87	**499781.08**	
Provider-					**25647255.79**	

GRAND TOTAL:	**1323060281.40**
Total Estimated Unduplicated Participants:	**29819**
Factor D (Divide total by number of participants):	**44369.71**
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
managed	*per hour*	*26711*	*21.38*	*44.91*		
Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services) Total:						***1016817229.28***
Residential Support, Pervasive Plus	*per day*	*128*	*338.11*	*269.37*	***11657816.41***	
Supervised Living, Extensive	*per day*	*443*	*320.36*	*159.67*	***22660283.37***	
Host Home/Companion Care, Extensive	*per day*	*3062*	*346.60*	*97.36*	***103327116.51***	
Host Home/Companion Care, Limited	*per day*	*7688*	*349.90*	*78.80*	***211974458.56***	
Supervised Living, Pervasive	*per day*	*138*	*308.93*	*181.36*	***7731801.18***	
Host Home/Companion Care, Intermittent	*per day*	*4536*	*355.37*	*75.10*	***121058069.83***	
Host Home /Companion Care, Pervasive	*per day*	*1355*	*348.39*	*123.35*	***58229643.31***	
Supervised Living, Limited	*per day*	*1727*	*335.93*	*146.91*	***85229999.57***	
Residential Support, Extensive	*per day*	*1878*	*340.92*	*159.67*	***102228359.84***	
Supervised Living, Intermittent	*per day*	*1133*	*331.80*	*138.15*	***51934646.61***	
Residential Support, Limited	*per day*	*3246*	*334.24*	*146.91*	***159388982.01***	
Host Home/Companion Care, Pervasive Plus	*per day*	*22*	*343.51*	*153.01*	***1156330.23***	
Supervised Living, Pervasive Plus	*per day*	*19*	*341.21*	*269.37*	***1746323.02***	
Residential Support, Pervasive	*per day*	*783*	*323.87*	*181.36*	***45991120.49***	
Residential Support, Intermittent	*per day*	*757*	*310.79*	*138.15*	***32502278.34***	
Social Work Total:						***11385.53***
Social Work	*per hour*	*40*	*4.62*	*61.61*	***11385.53***	
Supported Home Living Total:						***4642140.62***

GRAND TOTAL:	***1323060281.40***
Total Estimated Unduplicated Participants:	***29819***
Factor D (Divide total by number of participants):	***44369.71***
Average Length of Stay on the Waiver:	*355*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CDS	per hour	659	173.78	23.50	2691243.97	
Provider-managed	per hour	1427	72.45	18.87	1950896.65	
Transition Assistance Services Total:						121405.57
Transition Assistance Services- Minor Home Modifications	per Item	2	1.09	7953.44	17338.50	
Transition Assistance Services	per Item	93	1.09	1025.68	103973.18	
Transition Assistance Services- Assessments for Minor Home Modifications	per Item	1	11.84	7.93	93.89	

GRAND TOTAL:	1323060281.40
Total Estimated Unduplicated Participants:	29819
Factor D (Divide total by number of participants):	44369.71
Average Length of Stay on the Waiver:	355

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
Individualized Skills and Socialization Total:						226711654.84
Individualized Skills and Socialization, Intermittent	per day	4347	195.13	48.19	40876209.00	
Individualized Skills and Socialization, Limited	per day	4400	417.84	52.52	96557809.92	
Individualized Skills and Socialization, Pervasive	per day	9756	35.30	73.26	25229776.97	

GRAND TOTAL:	1362773160.29
Total Estimated Unduplicated Participants:	29819
Factor D (Divide total by number of participants):	45701.50
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individualized Skills and Socialization, Extensive	per day	1839	435.60	73.26	58686270.98	
Individualized Skills and Socialization, Pervasive Plus	per day	162	207.63	159.40	5361587.96	
Respite Total:						5793458.87
Provider-managed	per hour	777	173.50	20.14	2715063.33	
CDS	per hour	931	173.39	19.07	3078395.54	
Supported Employment Total:						1173970.64
CDS	per hour	15	250.85	34.22	128761.30	
Provider-managed	per hour	332	89.21	35.29	1045209.34	
Adaptive Aids Total:						4609005.79
Adaptive Aids	per item	6165	5.58	133.98	4609005.79	
Audiology Total:						14557.83
Audiology	per hour	3	86.33	56.21	14557.83	
Occupational Therapy Total:						1638069.51
Occupational Therapy	per hour	714	29.50	77.77	1638069.51	
Physical Therapy Total:						2426066.85
Physical Therapy	per hour	874	33.63	82.54	2426066.85	
Prescribed Drugs Total:						474176.87
Prescribed Drugs	per prescription	1018	7.98	58.37	474176.87	
Speech and Language Pathology Total:						5355678.10
Speech and Language Pathology	per hour	1530	43.04	81.33	5355678.10	
Financial Management Services Total:						3072379.58
Financial Management Services	per month	1341	10.23	223.96	3072379.58	
Support						53.60

GRAND TOTAL:	1362773160.29
Total Estimated Unduplicated Participants:	29819
Factor D (Divide total by number of participants):	45701.50
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultation Total:						
Support Consultation	per hour	3	1.09	16.39	**53.60**	
Behavioral Support Total:						**11343566.54**
Behavioral Support	per hour	6851	19.53	84.78	**11343566.54**	
Cognitive Rehabilitation Therapy Total:						**55015.13**
Provider-managed	per hour	5	122.46	84.78	**51910.79**	
CDS	per hour	1	37.08	83.72	**3104.34**	
Dental Treatment Total:						**18260913.96**
Dental Treatment	per visit	16581	1.98	556.22	**18260913.96**	
Dietary Services Total:						**244755.15**
Dietary Services	per hour	1251	3.32	58.93	**244755.15**	
Employment Assistance Total:						**1484266.70**
CDS	per hour	5	140.83	34.22	**24096.01**	
Provider-managed	per hour	249	166.17	35.29	**1460170.69**	
Minor Home Modifications Total:						**924963.53**
Minor Home Modifications	per item	148	1.14	5482.24	**924963.53**	
Nursing Total:						**26933034.33**
CDS	per hour	16	712.02	45.19	**514818.94**	
Provider-managed	per hour	26711	21.38	46.26	**26418215.39**	
Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services) Total:						**1047339450.55**
Residential Support, Pervasive Plus	per day	128	338.11	277.45	**12007503.30**	
Supervised Living, Extensive	per day	443	320.36	164.46	**23340077.68**	
Host					**106426080.98**	

GRAND TOTAL:	**1362773160.29**
Total Estimated Unduplicated Participants:	**29819**
Factor D (Divide total by number of participants):	**45701.50**
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home/Companion Care, Extensive	per day	3062	346.60	100.28		
Host Home/Companion Care, Limited	per day	7688	349.90	81.17	218349832.50	
Supervised Living, Pervasive	per day	138	308.93	186.80	7963721.11	
Host Home/Companion Care, Intermittent	per day	4536	355.37	77.35	124684976.05	
Host Home /Companion Care, Pervasive	per day	1355	348.39	127.05	59976296.57	
Supervised Living, Limited	per day	1727	335.93	151.32	87788465.97	
Residential Support, Extensive	per day	1878	340.92	164.46	105295146.61	
Supervised Living, Intermittent	per day	1133	331.80	142.30	53494753.62	
Residential Support, Limited	per day	3246	334.24	151.32	164173580.81	
Host Home/Companion Care, Pervasive Plus	per day	22	343.51	157.60	1191017.87	
Supervised Living, Pervasive Plus	per day	19	341.21	277.45	1798705.58	
Residential Support, Pervasive	per day	783	323.87	186.80	47370651.23	
Residential Support, Intermittent	per day	757	310.79	142.30	33478640.67	
Social Work Total:						11727.41
Social Work	per hour	40	4.62	63.46	11727.41	
Supported Home Living Total:						4781346.79
CDS	per hour	659	173.78	24.21	2772553.89	
Provider-managed	per hour	1427	72.45	19.43	2008792.89	
Transition Assistance Services Total:						125047.74
Transition Assistance Services- Minor Home Modifications	per Item	2	1.09	8192.05	17858.67	
Transition					107092.34	

GRAND TOTAL:	1362773160.29
Total Estimated Unduplicated Participants:	29819
Factor D (Divide total by number of participants):	45701.50
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistance Services	per Item	93	1.09	1056.45		
Transition Assistance Services- Assessments for Minor Home Modifications	per Item	1	11.84	8.17	96.73	
				GRAND TOTAL:		1362773160.29
				Total Estimated Unduplicated Participants:		29819
				Factor D (Divide total by number of participants):		45701.50
				Average Length of Stay on the Waiver:		355

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
Individualized Skills and Socialization Total:						233287357.19
Individualized Skills and Socialization, Intermittent	per day	4347	195.13	49.58	42055248.85	
Individualized Skills and Socialization, Limited	per day	4400	417.84	54.05	99370708.80	
Individualized Skills and Socialization, Pervasive	per day	9756	35.30	75.38	25959876.98	
Individualized Skills and Socialization, Extensive	per day	1839	435.60	75.38	60384535.99	
Individualized Skills and Socialization, Pervasive Plus	per day	162	207.63	164.02	5516986.56	
Respite Total:						5960432.73
Provider-managed	per hour	777	173.50	20.72	2793252.84	
CDS	per hour				3167179.89	
				GRAND TOTAL:		1402280758.28
				Total Estimated Unduplicated Participants:		29819
				Factor D (Divide total by number of participants):		47026.42
				Average Length of Stay on the Waiver:		355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		931	173.39	19.62		
Supported Employment Total:						**1207905.84**
CDS	per hour	15	250.85	35.21	**132486.43**	
Provider-managed	per hour	332	89.21	36.31	**1075419.41**	
Adaptive Aids Total:						**4742824.51**
Adaptive Aids	per hour	6165	5.58	137.87	**4742824.51**	
Audiology Total:						**14979.98**
Audiology	per hour	3	86.33	57.84	**14979.98**	
Occupational Therapy Total:						**1685461.26**
Occupational Therapy	per hour	714	29.50	80.02	**1685461.26**	
Physical Therapy Total:						**2496609.14**
Physical Therapy	per hour	874	33.63	84.94	**2496609.14**	
Prescribed Drugs Total:						**486524.80**
Prescribed Drugs	per prescription	1018	7.98	59.89	**486524.80**	
Speech and Language Pathology Total:						**5511086.93**
Speech and Language Pathology	per hour	1530	43.04	83.69	**5511086.93**	
Financial Management Services Total:						**3161412.19**
Financial Management Services	per month	1341	10.23	230.45	**3161412.19**	
Support Consultation Total:						**55.13**
Support Consultation	per hour	3	1.09	16.86	**55.13**	
Behavioral Support Total:						**11672714.62**
Behavioral Support	per hour	6851	19.53	87.24	**11672714.62**	
Cognitive Rehabilitation Therapy Total:						**56611.12**
Provider-managed					**53417.05**	

GRAND TOTAL:	**1402280758.28**
Total Estimated Unduplicated Participants:	**29819**
Factor D (Divide total by number of participants):	**47026.42**
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	per hour	5	122.46	87.24		
CDS	per hour	1	37.08	86.14	3194.07	
Dental Treatment Total:						18790467.99
Dental Treatment	per visit	16581	1.98	572.35	18790467.99	
Dietary Services Total:						251857.32
Dietary Services	per hour	1251	3.32	60.64	251857.32	
Employment Assistance Total:						1527167.66
CDS	per hour	5	140.83	35.21	24793.12	
Provider-managed	per hour	249	166.17	36.31	1502374.54	
Minor Home Modifications Total:						951786.64
Minor Home Modifications	per item	148	1.14	5641.22	951786.64	
Nursing Total:						27713207.05
CDS	per hour	16	712.02	46.50	529742.88	
Provider-managed	per hour	26711	21.38	47.60	27183464.17	
Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services) Total:						1077701112.66
Residential Support, Pervasive Plus	per day	128	338.11	285.50	12355891.84	
Supervised Living, Extensive	per day	443	320.36	169.23	24017033.60	
Host Home/Companion Care, Extensive	per day	3062	346.60	103.19	109514432.55	
Host Home/Companion Care, Limited	per day	7688	349.90	83.52	224671405.82	
Supervised Living, Pervasive	per day	138	308.93	192.22	8194788.39	
Host Home/Companion Care, Intermittent	per day	4536	355.37	79.60	128311882.27	
Host Home /Companion	per day				61718229.15	

GRAND TOTAL:	1402280758.28
Total Estimated Unduplicated Participants:	29819
Factor D (Divide total by number of participants):	47026.42
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care, Pervasive		1355	348.39	130.74		
Supervised Living, Limited	per day	1727	335.93	155.70	90329527.83	
Residential Support, Extensive	per day	1878	340.92	169.23	108349128.42	
Supervised Living, Intermittent	per day	1133	331.80	146.42	55043582.75	
Residential Support, Limited	per day	3246	334.24	155.70	168925631.33	
Host Home/Companion Care, Pervasive Plus	per day	22	343.51	162.18	1225629.94	
Supervised Living, Pervasive Plus	per day	19	341.21	285.50	1850893.64	
Residential Support, Pervasive	per day	783	323.87	192.22	48745110.17	
Residential Support, Intermittent	per day	757	310.79	146.42	34447944.95	
Social Work Total:						12067.44
Social Work	per hour	40	4.62	65.30	12067.44	
Supported Home Living Total:						4920441.61
CDS	per hour	659	173.78	24.91	2852718.61	
Provider-managed	per hour	1427	72.45	20.00	2067723.00	
Transition Assistance Services Total:						128674.46
Transition Assistance Services- Minor Home Modifications	per Item	2	1.09	8429.62	18376.57	
Transition Assistance Services	per Item	93	1.09	1087.09	110198.31	
Transition Assistance Services- Assessments for Minor Home Modifications	per Item	1	11.84	8.41	99.57	

GRAND TOTAL:	1402280758.28
Total Estimated Unduplicated Participants:	29819
Factor D (Divide total by number of participants):	47026.42
Average Length of Stay on the Waiver:	355

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*
Individualized Skills and Socialization Total:						***239813825.99***
Individualized Skills and Socialization, Intermittent	*per day*	*4347*	*195.13*	*50.97*	***43234288.71***	
Individualized Skills and Socialization, Limited	*per day*	*4400*	*417.84*	*55.56*	***102146837.76***	
Individualized Skills and Socialization, Pervasive	*per day*	*9756*	*35.30*	*77.49*	***26686533.13***	
Individualized Skills and Socialization, Extensive	*per day*	*1839*	*435.60*	*77.49*	***62074790.32***	
Individualized Skills and Socialization, Pervasive Plus	*per day*	*162*	*207.63*	*168.61*	***5671376.08***	
Respite Total:						***6127406.59***
Provider-managed	*per hour*	*777*	*173.50*	*21.30*	***2871442.35***	
CDS	*per hour*	*931*	*173.39*	*20.17*	***3255964.24***	
Supported Employment Total:						***1241841.04***
CDS	*per hour*	*15*	*250.85*	*36.20*	***136211.55***	
Provider-managed	*per hour*	*332*	*89.21*	*37.33*	***1105629.49***	
Adaptive Aids Total:						***4875611.21***
Adaptive Aids	*per hour*	*6165*	*5.58*	*141.73*	***4875611.21***	
Audiology Total:						***15399.55***
Audiology	*per hour*	*3*	*86.33*	*59.46*	***15399.55***	
Occupational Therapy Total:						***1732642.38***
Occupational					***1732642.38***	

GRAND TOTAL:	***1441528797.69***
Total Estimated Unduplicated Participants:	***29819***
Factor D (Divide total by number of participants):	***48342.63***
Average Length of Stay on the Waiver:	*355*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapy	per hour	714	29.50	82.26		
Physical Therapy Total:						**2566563.58**
Physical Therapy	per hour	874	33.63	87.32	**2566563.58**	
Prescribed Drugs Total:						**500091.28**
Prescribed Drugs	per prescription	1018	7.98	61.56	**500091.28**	
Speech and Language Pathology Total:						**5665178.74**
Speech and Language Pathology	per hour	1530	43.04	86.03	**5665178.74**	
Financial Management Services Total:						**3249896.07**
Financial Management Services	per month	1341	10.23	236.90	**3249896.07**	
Support Consultation Total:						**56.67**
Support Consultation	per hour	3	1.09	17.33	**56.67**	
Behavioral Support Total:						**11999186.69**
Behavioral Support	per hour	6851	19.53	89.68	**11999186.69**	
Cognitive Rehabilitation Therapy Total:						**58194.87**
Provider-managed	per hour	5	122.46	89.68	**54911.06**	
CDS	per hour	1	37.08	88.56	**3283.80**	
Dental Treatment Total:						**19316738.98**
Dental Treatment	per visit	16581	1.98	588.38	**19316738.98**	
Dietary Services Total:						**258917.97**
Dietary Services	per hour	1251	3.32	62.34	**258917.97**	
Employment Assistance Total:						**1570068.63**
CDS	per hour	5	140.83	36.20	**25490.23**	
Provider-managed	per hour	249	166.17	37.33	**1544578.40**	

GRAND TOTAL:	**1441528797.69**
Total Estimated Unduplicated Participants:	**29819**
Factor D (Divide total by number of participants):	**48342.63**
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Minor Home Modifications Total:						**978437.65**
Minor Home Modifications	per hour	148	1.14	5799.18	**978437.65**	
Nursing Total:						**28487555.03**
CDS	per hour	16	712.02	47.80	**544552.90**	
Provider-managed	per hour	26711	21.38	48.93	**27943002.14**	
Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services) Total:						**1107868000.18**
Residential Support, Pervasive Plus	per day	128	338.11	293.49	**12701683.70**	
Supervised Living, Extensive	per day	443	320.36	173.97	**24689731.94**	
Host Home/Companion Care, Extensive	per day	3062	346.60	106.08	**112581558.34**	
Host Home/Companion Care, Limited	per day	7688	349.90	85.86	**230966078.83**	
Supervised Living, Pervasive	per day	138	308.93	197.60	**8424150.38**	
Host Home/Companion Care, Intermittent	per day	4536	355.37	81.82	**131890429.74**	
Host Home /Companion Care, Pervasive	per day	1355	348.39	134.40	**63445999.68**	
Supervised Living, Limited	per day	1727	335.93	160.06	**92858986.67**	
Residential Support, Extensive	per day	1878	340.92	173.97	**111383902.81**	
Supervised Living, Intermittent	per day	1133	331.80	150.52	**56584893.29**	
Residential Support, Limited	per day	3246	334.24	160.06	**173655982.98**	
Host Home/Companion Care, Pervasive Plus	per day	22	343.51	166.72	**1259939.72**	
Supervised Living, Pervasive Plus	per day	19	341.21	293.49	**1902692.74**	
Residential Support,	per day	783	323.87	197.60	**50109425.50**	

GRAND TOTAL:	**1441528797.69**
Total Estimated Unduplicated Participants:	**29819**
Factor D (Divide total by number of participants):	**48342.63**
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Pervasive						
Residential Support, Intermittent	per day	757	310.79	150.52	35412543.88	
Social Work Total:						12405.62
Social Work	per hour	40	4.62	67.13	12405.62	
Supported Home Living Total:						5058502.57
CDS	per hour	659	173.78	25.61	2932883.32	
Provider-managed	per hour	1427	72.45	20.56	2125619.24	
Transition Assistance Services Total:						132276.42
Transition Assistance Services- Minor Home Modifications	per day	2	1.09	8665.65	18891.12	
Transition Assistance Services	per day	93	1.09	1117.52	113283.00	
Transition Assistance Services- Assessments for Minor Home Modifications	per day	1	11.84	8.64	102.30	

GRAND TOTAL:	1441528797.69
Total Estimated Unduplicated Participants:	29819
Factor D (Divide total by number of participants):	48342.63
Average Length of Stay on the Waiver:	355

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
Individualized Skills and Socialization Total:						246539248.80
Individualized					44447257.76	

GRAND TOTAL:	1481933442.74
Total Estimated Unduplicated Participants:	29819
Factor D (Divide total by number of participants):	49697.62
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Skills and Socialization, Intermittent	per day	4347	195.13	52.40		
Individualized Skills and Socialization, Limited	per day	4400	417.84	57.12	105014891.52	
Individualized Skills and Socialization, Pervasive	per day	9756	35.30	79.66	27433852.49	
Individualized Skills and Socialization, Extensive	per day	1839	435.60	79.66	63813108.74	
Individualized Skills and Socialization, Pervasive Plus	per day	162	207.63	173.33	5830138.28	
Respite Total:						6300305.16
Provider-managed	per hour	777	173.50	21.90	2952328.05	
CDS	per hour	931	173.39	20.74	3347977.11	
Supported Employment Total:						1276443.84
CDS	per hour	15	250.85	37.21	140011.93	
Provider-managed	per hour	332	89.21	38.37	1136431.92	
Adaptive Aids Total:						5011837.98
Adaptive Aids	per hour	6165	5.58	145.69	5011837.98	
Audiology Total:						15832.06
Audiology	per hour	3	86.33	61.13	15832.06	
Occupational Therapy Total:						1781297.91
Occupational Therapy	per hour	714	29.50	84.57	1781297.91	
Physical Therapy Total:						2638281.57
Physical Therapy	per hour	874	33.63	89.76	2638281.57	
Prescribed Drugs Total:						513170.34
Prescribed Drugs	per prescription	1018	7.98	63.17	513170.34	
Speech and Language Pathology Total:						5823880.13

GRAND TOTAL:	1481933442.74
Total Estimated Unduplicated Participants:	29819
Factor D (Divide total by number of participants):	49697.62
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech and Language Pathology	per hour	1530	43.04	88.44	5823880.13	
Financial Management Services Total:						3340986.44
Financial Management Services	per month	1341	10.23	243.54	3340986.44	
Support Consultation Total:						58.27
Support Consultation	per hour	3	1.09	17.82	58.27	
Behavioral Support Total:						12336362.77
Behavioral Support	per hour	6851	19.53	92.20	12336362.77	
Cognitive Rehabilitation Therapy Total:						59829.82
Provider-managed	per hour	5	122.46	92.20	56454.06	
CDS	per hour	1	37.08	91.04	3375.76	
Dental Treatment Total:						19857455.34
Dental Treatment	per visit	16581	1.98	604.85	19857455.34	
Dietary Services Total:						266144.75
Dietary Services	per hour	1251	3.32	64.08	266144.75	
Employment Assistance Total:						1613811.20
CDS	per hour	5	140.83	37.21	26201.42	
Provider-managed	per hour	249	166.17	38.37	1587609.78	
Minor Home Modifications Total:						1005832.72
Minor Home Modifications	per item	148	1.14	5961.55	1005832.72	
Nursing Total:						29285201.96
CDS	per hour	16	712.02	49.14	559818.60	
Provider-managed	per hour	26711	21.38	50.30	28725383.35	
Residential Assistance (Host Home/Companion Care, Supervised						1138918840.78

GRAND TOTAL:	1481933442.74
Total Estimated Unduplicated Participants:	29819
Factor D (Divide total by number of participants):	49697.62
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Living, Residential Support Services) Total:						
Residential Support, Pervasive Plus	per day	128	338.11	301.71	**13057429.52**	
Supervised Living, Extensive	per day	443	320.36	178.84	**25380879.80**	
Host Home/Companion Care, Extensive	per day	3062	346.60	109.05	**115733587.26**	
Host Home/Companion Care, Limited	per day	7688	349.90	88.27	**237449054.02**	
Supervised Living, Pervasive	per day	138	308.93	203.14	**8660333.55**	
Host Home/Companion Care, Intermittent	per day	4536	355.37	84.12	**135597933.88**	
Host Home /Companion Care, Pervasive	per day	1355	348.39	138.16	**65220977.05**	
Supervised Living, Limited	per day	1727	335.93	164.54	**95458063.64**	
Residential Support, Extensive	per day	1878	340.92	178.84	**114501909.40**	
Supervised Living, Intermittent	per day	1133	331.80	154.74	**58171315.36**	
Residential Support, Limited	per day	3246	334.24	164.54	**178516527.80**	
Host Home/Companion Care, Pervasive Plus	per day	22	343.51	171.38	**1295156.36**	
Supervised Living, Pervasive Plus	per day	19	341.21	301.71	**1955982.91**	
Residential Support, Pervasive	per day	783	323.87	203.14	**51514315.26**	
Residential Support, Intermittent	per day	757	310.79	154.74	**36405374.96**	
Social Work Total:						**12753.05**
Social Work	per hour	40	4.62	69.01	**12753.05**	
Supported Home Living Total:						**5199887.81**
CDS	per hour	659	173.78	26.33	**3015338.46**	
Provider-managed	per hour	1427	72.45	21.13	**2184549.35**	

GRAND TOTAL:	**1481933442.74**
Total Estimated Unduplicated Participants:	**29819**
Factor D (Divide total by number of participants):	**49697.62**
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transition Assistance Services Total:						**135980.06**
Transition Assistance Services- Minor Home Modifications	per Item	2	1.09	8908.28	**19420.05**	
Transition Assistance Services	per Item	93	1.09	1148.81	**116454.87**	
Transition Assistance Services- Assessments for Minor Home Modifications	per Item	1	11.84	8.88	**105.14**	

GRAND TOTAL:	**1481933442.74**
Total Estimated Unduplicated Participants:	**29819**
Factor D (Divide total by number of participants):	**49697.62**
Average Length of Stay on the Waiver:	355